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January 1978

BALCONY
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Association

Mississippi

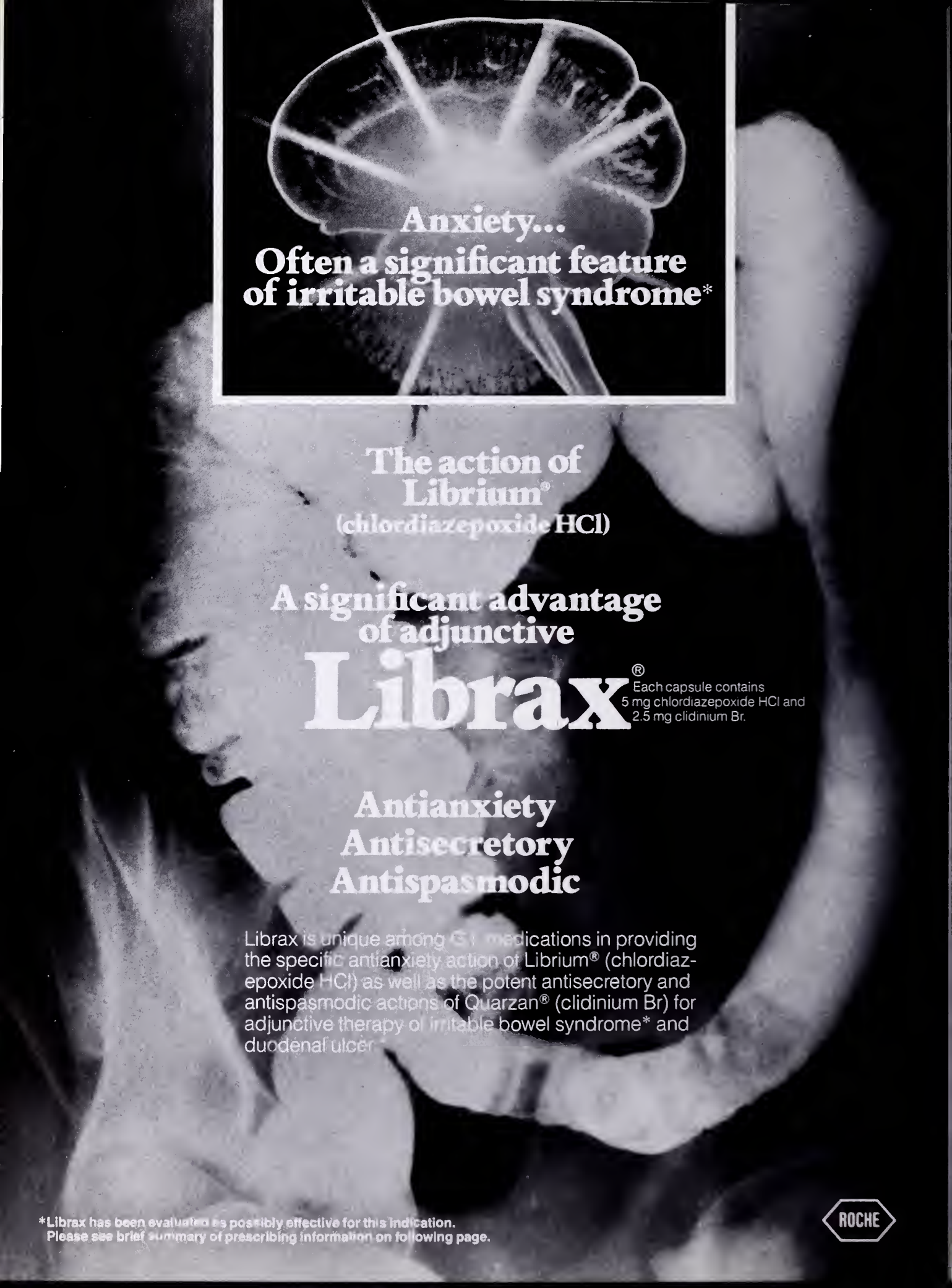


Contents:

Gangrenous Bowel Obstruction

First Three Years of Hypertension Screening by Mississippi Heart Association

Radionuclide Bone Scanning in the Diagnosis of Acute Osteomyelitis


Anxiety...
Often a significant feature
of irritable bowel syndrome*
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"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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St. Dominic's Breaks Ground for New Addition

A combined groundbreaking and blessing was held Friday, Dec. 9, for the new $1,333,000 addition to St. Dominic-Jackson Memorial Hospital.

The Diagnostic and Educational Unit Complex will be built over the Dietary Department located at ground level on the west central side of the hospital. Foundation to support the additional four floors was laid at the time the dietary area was built.

Construction is expected to take around eight months and should be completed by Sept. 1, 1978.

On hand for the groundbreaking was Mother Mary Dominica, O.P., of Springfield, IL, Mother General of the Dominican Sisters who operate St. Dominic Hospital. With her were four members of the General Council of the order—Sr. Mary Gloria, Sr. Mary Aquinas, Sr. Margaret Rose and Sr. Mary Lawrence.

First floor level of the expansion will be used for a new endoscopic unit and for the consolidation of all nuclear medicine services. This unit will bring together in one area all endoscopic procedures now being performed in the hospital. These services have been fragmented between the Emergency Suite, Operating Suite and Radiology Department.

Second floor will be partially developed to house the new Patient Education Department, and enlargement of inservice education facilities including office space for instructors. The remainder of the space will be utilized for the expansion of the Mississippi Heart Institute, St. Dominic's cardiovascular services.

Third floor will provide for an expansion of surgery's adjunct facilities—dressing rooms, anesthesiology offices, inservice/conference area, Operating Room Director's office and additional storage. The remaining area will be planned for future Outpatient Surgical Services.

Fourth floor will include expanding Respiratory Therapy and Special Diagnostic Services treatment equipment and supply storage. Space is planned for the future expansion of outpatient services for both Respiratory Therapy and Physical Therapy.

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The Public Speaks Out on Health

Americans think the two most effective means of improving people's health is to (1) provide comprehensive health insurance coverage for all Americans and (2) stop the rise of medical care costs.

In a survey conducted by the Health Insurance Institute, Americans were asked their opinions of 10 ways to improve people's health.

Provision of comprehensive health insurance was the most frequent response, offered by 28 per cent, while 23 per cent said putting a lid on rising health costs. Another 18 per cent felt better health could be achieved by encouraging people to "modify personal habits that lead to poor health." Twelve per cent pointed to more health education, including such things as diet and exercise.

Very few respondents thought there was a need for more doctors or hospitals, while two per cent cited each of those possibilities.

FTC Investigates Blues' Merger

The Federal Trade Commission has begun an investigation into a proposed consolidation of the Blue Cross Association and the National Association of Blue Shield Plans to determine possible antitrust violations.

In a letter to Sen. Howard Metzenbaum (D.-Ohio), FTC Commissioner Michael Pertschuk said that subpoenas had already been issued to obtain documents and records pertaining to the previously announced staff consolidation and that "an expeditious, but thorough inquiry" would be conducted to find the "potential impact on competition in the health coverage market."

Spokesman for the national associations of Blue Cross and Blue Shield denied that the impending staff consolidation could be "legally" regarded as a merger and added that they would "cooperate fully" with the latest FTC investigation, even though they feel "the entire matter is based on completely erroneous facts."

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January 1978



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CONTENTS

ORIGINAL SCIENTIFIC PAPERS

Gangrenous Bowel Obstruction **1** William O. Barnett, M.D., Jackson, MS

The First Three Years of Blood Pressure Screening by Mississippi Heart Association **5** Thomas R. Sharpe, Ph.D., University, MS

SPECIAL ARTICLE

Radiologic Seminar CLXXVII: Radionuclide Bone Scanning in the Diagnosis of Acute Osteomyelitis **10** Jordan H. Hankins, M.D., and W. Mel Flowers, Jr., M.D., Jackson, MS

EDITORIAL

AAMA-Mississippi Society **15** Myron W. Lockey, M.D., Jackson, MS

THIS MONTH

The President Speaking **14** Some New Year's Resolutions

Medical Organization **19** Board of Trustees Holds Fall Meeting

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Working Poor Are Without Health Coverage

A study released recently indicates that 94 per cent of the American public has some sort of health care protection; that 6 per cent, or some 12.2 million people, have none at all—and that most of those with no protection whatever are among the so-called "working poor."

The findings are the results of 18 months of work by an independent research team to determine how many people are in the unprotected category and who they are. For the purpose of the study, "coverage" was defined as protection against the expenses of hospitalization and in-hospital physician care.

In *National Health Insurance Issues: The Unprotected Population,* Washington-based researchers Stephen G. Sudovar, Jr., and Kathleen Sullivan reveal that the number of Americans in the "gap" between private insurance coverage and public assistance is much lower than has been widely believed.

A recent Congressional Budget Office estimate put the unprotected figure at 18 million persons, while other estimates have ranged as high as 40 million.

The study also relates that for the most part, people in the gap are those who are unemployed, underemployed, self-employed, or in such poor health to begin with that they are virtually uninsurable. Half of them—almost 7 million—earn less than $10,000 a year per family.

In short, they are neither poor enough to qualify for Medicaid, old enough to apply for Medicare, nor financially able or healthy enough to buy private coverage on their own, the study says.

The Sudovar-Sullivan study was made possible by a grant from Roche Laboratories, a division of Hoffmann-La Roche Inc., one in a series of reports and studies on health care matters by various authors which the diversified health care firm plans to make public over the next several months.

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Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

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Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

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1977 publication which features: economic factors, advantages and disadvantages of incorporation; effect of ERISA on professional corporations; choosing a retirement plan; and managing a professional corporation.

8 **New Doctor's Kit** (OP-458) $10.00
Contains: **The Business Side of Medical Practice; Planning Guide for Physicians' Medical Facilities; AMA Publications Lists; Group Practice Guidelines; Current Procedural Terminology** order form; Uniform Health Insurance Claim Form; **Medicolegal Forms; Talking with Patients; Preparing a Patient Information Booklet;** AMA membership information; Placement Service; and bibliography on billing systems, recording keeping systems, etc.

9 **Group Practice Kit** (OP-457) $7.50
Contains: **Group Practice Guidelines; Professional Corporations in Perspective;** medicolegal reprints on such subjects as: professional liability, confidentiality, informed consent, etc.; samples of model legal agreements for a physician and employed associate, office sharing, medical partnerships, and forming a corporation.

Nation Spends Less for Poor

Total national health expenditures, including government contributions, were 20 per cent greater per capita for the more affluent that for the poor, and almost 60 per cent greater for whites than for racial minorities, a recent HEW report says.

Per capita health care expenditures averaged $258 for a white individual, $162 for a minority, $265 for a person above the poverty line, and $213 for a poor person, according to the HEW study.

The report also shows higher mortality rates in large city poverty areas among minorities than among whites, and higher levels of disability among the poor.

Racial minorities, which comprise more than 40 per cent of the nation's poor, the report said, suffer five times the tuberculosis mortality rate than white Americans do, three-and-a-half times the maternal fatality rate, and a 42 per cent greater overall mortality rate.

Administration Urges More HMOs

The Carter Administration's new-found love affair with health maintenance organization (HMOs), an old flame of the Nixon Administration, is flourishing.

HEW Secretary Joseph Califano has invited 500 large corporation representatives to Washington, D. C., Feb. 7 to make a pitch for their establishment of HMOs for their employees to replace fee-for-service, regular health insurance plans.

Califano made the announcement at a ceremony in New York City certifying the huge, 3.25 million-member Kaiser-Permanente prepaid health plan as an HMO.

In addition to meeting with corporations, Califano is expected to sit down with labor leaders to urge them to push HMOs in conjunction with the management effort.

In the drive to promote establishment of the prepaid plans, Califano said HEW has cut qualification time for new HMOs by almost 40 per cent by assigning extra staff and streamlining the paper work.

AMA Urges More Dollars for Prevention

The AMA has recommended that the Administration propose increased funding for programs emphasizing preventive health care and promoting cost effective delivery of services.

More federal funds were sought for venereal disease control, migrant and Indian health care, family planning and immunization programs for diseases such as polio and measles, and prevention and treatment of mental disorders and alcoholism.

In a letter to the White House Office of Management and Budget, the AMA asked that its recommendations be incorporated into President Carter's fiscal 1979 budget slated to be sent to Congress early next year.

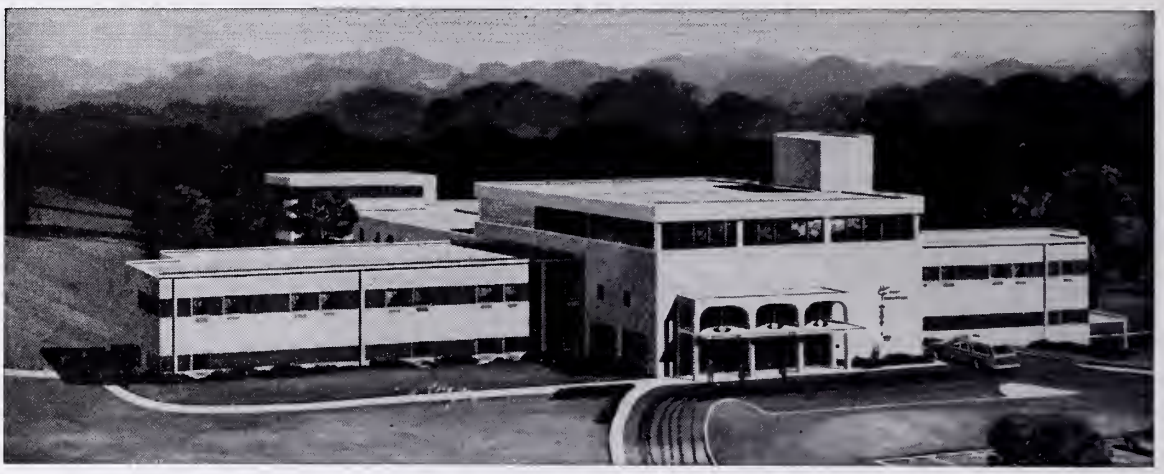
Largest recommended increase was $250 million for National Institutes of Health disease and injury research and treatment programs. The AMA also asked increases for services to older Americans, for prevention and treatment of mental disorders, for health services to mothers and children, for health care for Indians, and for alcoholism.

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NEWSLETTER

January 1978

Dear Doctor:

The Mississippi State Board of Health has announced a voluntary mammography quality assurance program to assist radiological facilities in identifying unproductive radiologic exposure. The new program, which is called Breast Exposure: Nationwide Trends, has been tested in five states with over 95 per cent participation of the facilities in those states performing mammography. The SBH's Division of Radiological Health will implement the new program.

> According to SBH's Radiological Health Director, Eddie Fuente, "BENT has proven effective in minimizing patient exposure from mammography and in improving image quality." Facilities taking mammograms in Mississippi will be mailed complete details of the new program.

Mississippi physicians are reminded that the Southern Medical Association offers a toll free cancer education service. The system is quite simple--the physician calls an "800" number, tells the operator the number of the tape he or she wishes to hear, and the operator plays it over the telephone for them. There is never a charge for the call or service.

In August 1976 an 18-year-old Corinth youth was found to have far advanced active pulmonary tuberculosis which was bacillary drug resistant and State Board of Health investigators found that transmission of the disease had occurred. This is the first identified community outbreak of primary drug resistant TB according to the Tuberculosis Control Unit at Jackson (354-6663).

Congress voted to delay a proposed ban on saccharin as a food additive for 18 months while additional government studies are made to evaluate the health risks and benefits of using it as a sugar substitute. The artificial sweetener has been linked to bladder cancer in laboratory animals and last March the U. S. Food and Drug Administration requested it be taken off the market.

FDA has released an update on the toxicity of laetrile. Diversion of cancer patients from effective therapy remains the major hazard in the promotion and use of laetrile. Another hazard is that it contains cyanide, a potent and rapidly acting respiratory enzyme poison. Some 37 poisonings and 17 deaths have been reported. Other adverse reactions include hypotension, vomiting and diarrhea, etc.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

Female Infertility Is Studied in Memphis

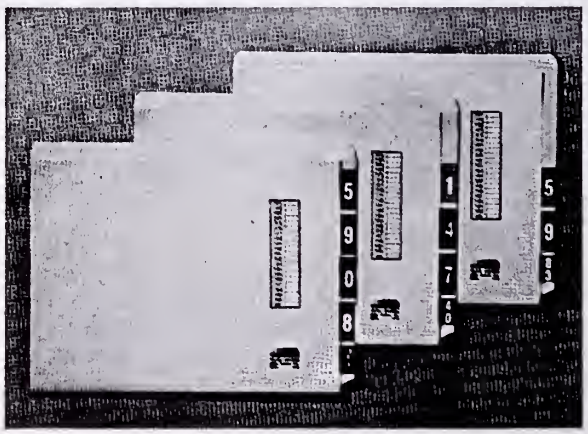
The University of Tennessee Center for the Health Sciences College of Medicine will present a symposium on "The Infertile Female" at the Holiday Inn Rivermont Hotel, Memphis, TN, Mar. 13-15, 1978.

Guest speakers will include Drs. G. E. Abraham, S. J. Behrman, R. Blandau, M. R. Cohen, V. Davajon, R. B. Greenblatt, J. M. Hershman, J. J. Hoffman, R. B. Jaffe, H. L. Judd, V. B. Mahesh, R. L. Malinak, J. R. Marshall, P. G. McDonough, A. M. Siegler, J. L. Simpson, N. Vorys, and E. Wilson. This symposium is designed as a postgraduate course for practicing physicians and is approved for 20 elective hours by the American Academy of Family Physicians and 25 cognates by the American College of Obstetricians and Gynecologists.

For further information contact: Division of Continuing Education, U.T.C.H.S., 800 Madison Avenue, Memphis, TN 38163. Telephone (901) 528-5547. Symposium director is James R. Givens, M.D.

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Surgical Forum V Is Set for March

Nearly 300 surgeons from as far away as Washington and New Hampshire are expected to attend the fifth annual University of Mississippi Postgraduate Surgical Forum Mar. 9-11 in Jackson.

The seminar is at the Holiday Inn Downtown, and is sponsored by the UMC School of Medicine and the Medical Center Division of Continuing Health Professional Education.

During the three-day forum, an international guest faculty will lecture and answer questions on topics of interest to general surgeons.

Coordinators are Dr. James D. Hardy, UMC professor of surgery and department chairman, and Dr. William O. Barnett, UMC professor of surgery.

Guests include Walter F. Ballinger, Bixby Professor of Surgery and head of the department, Washington University School of Medicine, St. Louis; Dr. Oliver H. Beahrs, department of surgery, Mayo Clinic and professor of surgery, Mayo Medical School, Rochester; Dr. J. Lynwood Herrington, Jr., associate clinical professor of surgery, Vanderbilt University Medical School, Nashville; Dr. William P. Longmire, professor and chairman, department of surgery, University of California, Center for the Health Sciences, Los Angeles; Dr. William C. McGarity, chief of surgery, Emory University Hospital, Atlanta; Dr. Norman D. Nigro, clinical professor of surgery, Wayne State University, Detroit;

Dr. John E. Ray, head of the colon and rectal surgery department, Ochsner Clinic and clinical associate professor of surgery, Tulane University School of Medicine, New Orleans; Dr. H. Harlan Stone, professor of surgery, Emory University School of Medicine, Atlanta; Dr. Watts R. Webb, professor and chairman, department of surgery, Tulane University School of Medicine, New Orleans; Professor R. B. Welbourn, Royal Postgraduate Medical School, University of London, Hammersmith Hospital, London, England; Dr. Claude E. Welch, clinical professor of surgery emeritus, Harvard Medical School, Boston; and Dr. George D. Zuidema, Warfield M. Firor professor and director, section of surgical sciences and surgeon-in-chief, the Johns Hopkins Hospital, Baltimore.

Attendance is by invitation and advance registration is required. For additional information write: Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216.

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* **INDICATIONS:** Based on a review of this preparation by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: **Possibly effective:** In cutaneous candidiasis; superficial bacterial infections; the following conditions when complicated by candidal and/or bacterial infection: atopic, eczematoid, stasis, nummular, contact, or seborrheic dermatitis, neurodermatitis, and dermatitis venenata; infantile eczema; lichen simplex chronicus; and pruritus ani and pruritus vulvae.

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Viral diseases of the skin (such as vaccinia and varicella); fungal lesions of the skin except candidiasis; history of hypersensitivity to any product component. Not intended for ophthalmic use; should not be applied in the external auditory canal of patients with perforated eardrums; should not be used when circulation is markedly impaired.

WARNINGS: Because of the potential hazard of nephrotoxicity and ototoxicity, prolonged use or use of large amounts of this product should be avoided in the treatment of skin infections following extensive burns, trophic ulceration, and other conditions where absorption of neomycin is possible.

Usage in Pregnancy: Although topical steroids have not been reported to have an adverse effect on the fetus, the safety of topical steroids during pregnancy has not been absolutely established; therefore, do not use extensively on pregnant patients, in large amounts, or for prolonged periods.

PRECAUTIONS: Watch constantly for overgrowth of nonsusceptible organisms (including fungi other than candida). Should superinfection due to nonsusceptible organisms occur, administer suitable concomitant antimicrobial therapy; if favorable response is not prompt, discontinue the preparation until adequate control by other anti-infectives is effected. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid; suitable precautions should be taken. If irritation develops, discontinue the product and institute appropriate therapy.

ADVERSE REACTIONS: Sensitivity reactions to topical use of gramicidin are rare. Hypersensitivity to nystatin is extremely uncommon. Hypersensitivity to neomycin has been reported and articles in the current medical literature indicate an increase in its prevalence.

The following local adverse reactions have been reported with topical corticosteroids either with or without occlusive dressings: burning sensations, itching, irritation, dryness, folliculitis, secondary infection, skin atrophy, striae, miliaria, hypertrichosis, acneform eruptions, maceration of the skin, and hypopigmentation. Contact sensitivity to a particular dressing material or adhesive may occur occasionally. Ototoxicity and nephrotoxicity have been reported.

For full prescribing information, consult package insert.

HOW SUPPLIED: Available in 15, 30, and 60 g. tubes. It is also available in jars of 120 g. (4 oz.) for hospital or institutional use only.

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Home-Study Pediatrics Course Offered

The 1978 edition of Primary Care of the Newborn, a home-study course in pediatrics for the family physician, has been announced by the Georgia Academy of Family Physicians Educational Foundation.

An optional in-person seminar/workshop will follow the home-study program.

This program is acceptable for 30 prescribed hours by the American Academy of Family Physicians.

As an organization accredited for continuing medical education, the G.A.F.P. Educational Foundation certifies that when these continuing medical education materials are used as directed, they meet the criteria for 30 hours of credit in Category I for the Physician's Recognition Award of the American Medical Association.

The G.A.F.P. Educational Foundation certified that this continuing medical education offering meets the criteria for 22 hours of credit in Category 5a for the Physician's Recognition Award of the American Medical Association.

Twenty-four areas of pediatrics are covered, presented in four two-week home-study sessions. The optional workshop will permit encounter with course authors and experts in the field.

The course offers comprehensive training, flexible scheduling, and the economy of $5 per CME hour. Total cost is $150 for AAFP members; $180 for nonmembers.

Enrollment deadline is Feb. 10, 1978; the course begins April 24. The optional seminar/workshop is scheduled in Atlanta June 24-25.

For a descriptive brochure, write: Registrar, Primary Care of the Newborn, 11 Corporate Square, Suite 205, Atlanta, GA 30329.

Pediatric Dermatology Seminar Is Planned

A three day pediatric dermatology seminar will begin Thursday evening, Feb. 23, 1978, at the Konover Hotel on the ocean front of Miami Beach, FL. The program will conclude on Sunday afternoon, Feb. 26, to be followed by a one week post seminar flight and cruise to the Caribbean and South America. Dr. R. Winkelmann of the Mayo Clinic will conduct daily lectures and discussions at Curacao, Caracas, Grenada, Guadaloupe, St. Thomas and San Jaun.

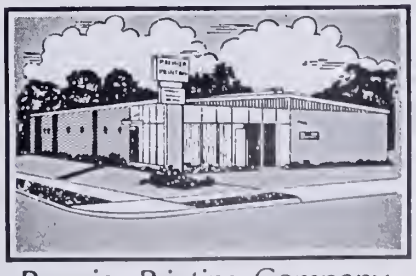
The course is designed to review the most recent advances about skin diseases of children. The format will be two 45 minute lectures followed by a 30 minute question and discussion period in which the audience can quiz the faculty. Continuing medical education credit will be awarded.

The faculty and their subjects include: Albert Kligman, Contact and Irritancy Dermatitis, Myths About Acne and Diaper Rashes; Richard Winkelmann, Bullous Diseases of Children, Review of Pediatric Dermatological Literature; Gerald Weissman, Inflammation and Infection—New Views and Therapy; Heinz Eichenwald, Neonatal Skin Abnormalities and Infectious Diseases of Children's Skin; Loren Golitz, Difficult and Practical Diagnostic Problems of Pediatric Dermatology Reviewed and Updated; William Awad, Internal Abnormalities of Children with Skin Disease; Guinter Kahn, New Thoughts, Types and Therapies—Hemangiomas.

The tuition is $150.00 for physicians and $100.00 for physicians in training. For further details write to Guinter Kahn, M.D., 16800 NW 2 Ave., Suite 401, North Miami Beach, FL 33169.

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DATELINE

Americans Satisfied with Health Care

Chicago, IL - Most Americans are well satisfied with the quality of their health care, a Gallup survey taken this fall indicated. The American people as a whole rate the quality of their health care quite high, the survey found. Even some groups often thought to be deprived--the elderly and rural residents--believe they receive high quality health care and are well satisfied with it. Public satisfaction with the last visit to a medical doctor is extremely high--90 per cent.

Rural Health Clinic Services Funded

Jackson, MS - A Rural Health Clinic Services Bill authorizing Medicare and Medicaid reimbursement for nurse practitioners and physician assistants services has been signed into law by President Carter. The bill authorizes cost reimbursement payments to medical clinics in medically underserved areas. There are several such clinics operating in Mississippi and Governor Finch recently announced an administration goal to establish more.

Caring for Former Mental Patients

New York, NY - The National Institute of Mental Health is funding a projected 5-year program to train professionals on the staffs of community mental health centers throughout the country in teaching former mental patients how to live again in a community setting. Model for the program will be Fountain House in New York City which began in the 1940s and pioneered in helping former patients train for and get jobs and adjust to living in apartments, etc.

Patient Wants More Drug Information

Washington, D.C. - Only a few prescription drugs now carry a patient package insert or labeling information. A recent FDA survey found that many consumers feel such labeling is a good idea. Study focused on oral contraceptives and involved 1,720 users and 949 former users. Some 88 per cent said they actually read the information. More than 85 per cent would like to see patient-oriented labeling instructions used for tranquilizers, antibiotics, and cough and cold preparations.

AMA Releases Cyclist Helmet Report

Chicago, IL - In a report entitled "Head Protection for the Cyclist, A Medical Inquiry," the AMA strongly recommended that no one should operate or ride as a passenger on a motorcycle, moped, or even bicycle without wearing a helmet. The report also recommends the use of full-facial coverage helmets because of the extra protection they afford and urges the medical and health community to actively involve itself in promoting the use of safety helmets.

Mississippi Medicaid Seeks Increased Fees

The Mississippi Medicaid Commission has formally gone on record for an increase in reimbursement for physicians' services under the program.

At a recent meeting, on motion by Commission member Senator William G. Burgin of Columbus, the commission unanimously voted to seek legislative authority to replace the present F-300 payment schedule with the F-450.

The F-300 physician payment schedule was written into the Medicaid Enabling Act when it was passed by the Mississippi Legislature in 1969.

The commission also acted to establish new administrative procedures to provide payments for surgical visits as well as surgery and to provide payments for additional physicians on a case when the attending physician certified that the additional physicians were medically necessary. Physicians will be notified by the commission when the latter administrative procedures are operational.

An increase in Medicaid reimbursement to physicians is one of MSMA's 1978 legislative recommendations.

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Computer Link-up Saves Time for Claims Payment

Computer to computer communication between University Hospital at the University of Mississippi Medical Center and the Blue Cross-Blue Shield of Mississippi office in Jackson eliminates more than half the usual time from patient discharge to payment of insurance claims.

ESC, electronic submission of claims, makes more efficient use of man hours and saves money by increasing cash flow. Assistant UH director Edward Tucker estimates the University will save more than $252,000 in the next five years, "a big plus in the cost containment column."

The manual system of handling a routine insurance claim, from filing to payment, takes about 45 days considering weekends, holidays, mail time and all the people who have to see it, Tucker said.

ESC reduces that time to 15 days on individual patient accounts. "We can process twice the number of claims in one-eighth the time," says UH insurance claims manager Bill Vandergriff.

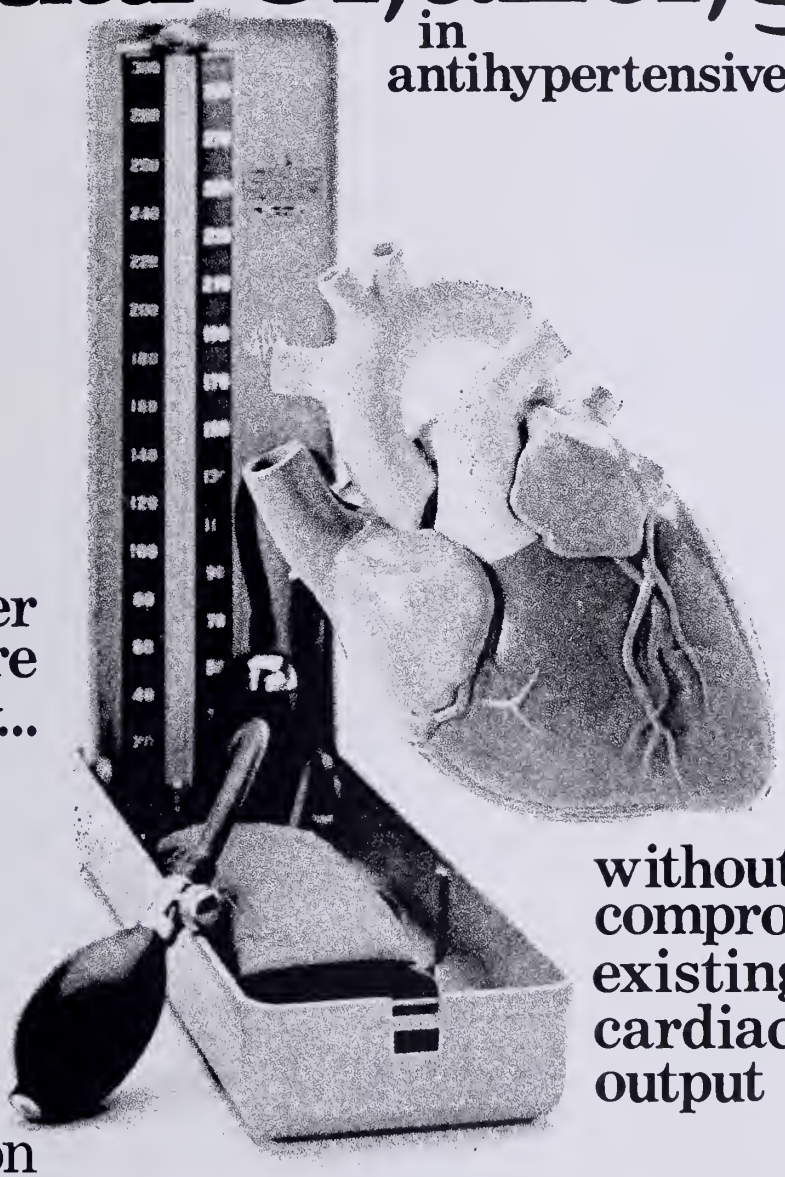
Time consuming paper handling is avoided at both ends, according to Ed McIntosh, director of special projects at Blue Cross. On Nov. 21, only 21 of the 125 claims processed through ESC had to be examined by clerks. The 104 routine claims, checked for error by computer at UMC and then again at Blue Cross, went immediately to the professional review stage and were then approved for payment. The necessity of filing those 104 was eliminated. No claims were lost, and none wound up at the bottom of a stack.

"Reviewing routine claims is monotonous—a situation that leads to human error," said UH patient accounts manager Jim Elliott. "A computer does it quickly and without errors, freeing clerk time for the more complicated claims."

The UH/Blue Cross link for processing insurance claims may be the first project of such scope in the nation. St. Dominic's in Jackson is also on ESC with Blue Cross, and more hospitals in the state are expected to follow suit. At the University, all emergency room and inpatient claims for Blue Cross and Medicaid are processed through ESC. By spring 1978, the teaching hospital expects to include Blue Cross and Medicaid outpatient claims, putting more than half the total volume on ESC, Tucker said. If the Department of Health, Education and Welfare approves Medicare claims for inclusion, approximately two-thirds of the hospital's total claims volume will be processed by ESC.

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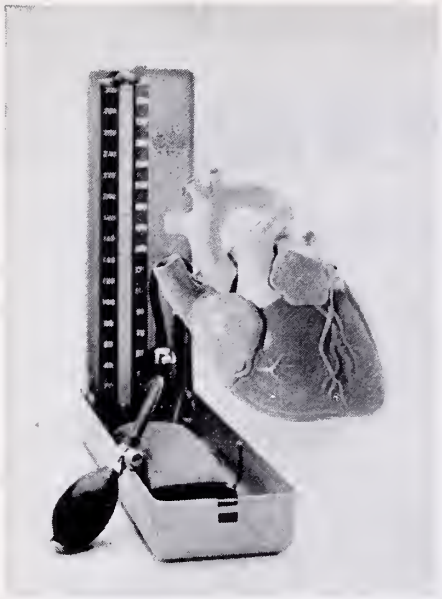
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With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, occasionally with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy

Pregnancy and Nursing: Use of any drug in women who are or may become pregnant or intend to nurse requires that anticipated benefits be weighed against possible risks; possibility of fetal injury or injury to a nursing infant cannot be excluded. Methyldopa crosses the placental barrier, appears in cord blood, and appears in breast milk.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: urinary uric acid by the phosphotungstate method, serum creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia. Positive tests for antinuclear antibody, LE cells, and rheumatoid factor.

Allergic: Drug-related fever, lupus-like syndrome, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third months of therapy; increased dosage or adding a diuretic frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 500.

For more detailed information, consult your MSD representative or see full prescribing information.

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All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

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1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974

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Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, or on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 10 mg to 25 mg t.i.d. Increase or decrease the dosage according to individual response. **Usual optimum daily dosage is 75 mg to 150 mg** per day, not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
January 1978, Vol. XIX, No. 1

ORIGINAL PAPERS

Gangrenous Bowel Obstruction

WILLIAM O. BARNETT, M.D.
Jackson, Mississippi

A review of 151 cases of irreversible bowel gangrene at University Medical Center is presented. The author points out the main causes of complete bowel obstruction: hernia, adhesions or mesenteric insufficiency, and in an effort to help improve results, discusses diagnosis, early operation, nasogastric suction, optimal preoperative preparation, operative techniques, technical errors, length of resected bowel, postoperative care, age, late pathophysiologic changes and achievable mortality goals.

DURING A REVIEW of 151 cases in which irreversible bowel gangrene was discovered, we found that 86 per cent resulted from either hernia, adhesions, or mesenteric insufficiency (see Figure 1). The mortality rate for the entire series was 37 per cent.[1] These cases include only those instances of irreversible gangrene which necessitated resection at the time of surgery or were discovered during postmortem examination. Those cases in which strangulation was observed at the time of operative exposure, but regained normal circulation after release of the obstructing mechanism, were excluded. The remaining 14 per cent which yielded a mortality of 28 per cent included intussusception, carcinomatosis, annular pancreas, diverticulitis, congenital reduplication, pancreatitis and volvulus. Subsequent comments in this discussion will be concerned only with bowel gangrene resulting from hernia, adhesions, and mesenteric insufficiency.

Hernia

There were 45 patients who presented with bowel gangrene secondary to hernia. They were equally divided between male and female. The mortality rate for the entire group was 20 per cent. Those patients under 50 years of age experienced a mortality rate of 5 per cent while 23 per cent were lost in the older group. In 37 cases where dependable information was available, those operated on less than 36 hours after the onset of symptoms experienced a mortality rate of 5 per cent while this figure was 25 per cent among those with a greater delay.

In 22 cases, inguinal hernia was responsible for the problem while the second most common causative hernia was the ventral (incisional-umbilical) type.

From the Department of Surgery, University of Mississippi Medical Center, Jackson, MS.

Adhesions

Of the 43 patients with bowel gangrene from adhesions, 24 were female and 19 male. Twenty-three per cent of these patients failed to survive. There were 19 patients under 50 years of age and their mortality rate was 15 per cent. The older age group was attended by a mortality of 29 per cent. There were 13 patients operated on within 36 hours or less with a mortality rate of 8 per cent. Twenty-four per cent failed to survive when operated on more than 36 hours after onset of symptoms. When the length of resected bowel was less than 100 cm, 18 per cent were lost. In six cases where the resected specimen was greater than this length, all patients survived.

Mesenteric Insufficiency

The 42 patients in this group included those with arterial embolism and thrombosis, venous thrombosis, and low blood flow to the bowel without evidence of vessel occlusion. Seventy-four per cent of these patients failed to survive. The diagnosis was

made at postmortem examination in eight cases. Among the 34 patients who were explored, eight were closed without additional surgical efforts because of the extent of involvement. In the remaining 26 cases, bowel resection was effected with or without surgical efforts to restore blood flow. Among this group, the mortality rate was 66 per cent. Similarly dismal results have been reported by others including a mortality rate of 92 per cent by Ottinger and 85 per cent by Skinner.[3, 4]

Improving Results

Mesenteric insufficiency presents the most severe challenge for improving the survival rate among patients with gangrenous bowel. There were 28 instances among the 42 cases of this condition which we considered nonsalvagable because of extensive gangrene, hopeless cardiac problems, hepatic coma, and pulmonary embolism. Three patients may have been saved by earlier operative intervention, but this would only have lowered the mortality rate from 74 per cent to 67 per cent.

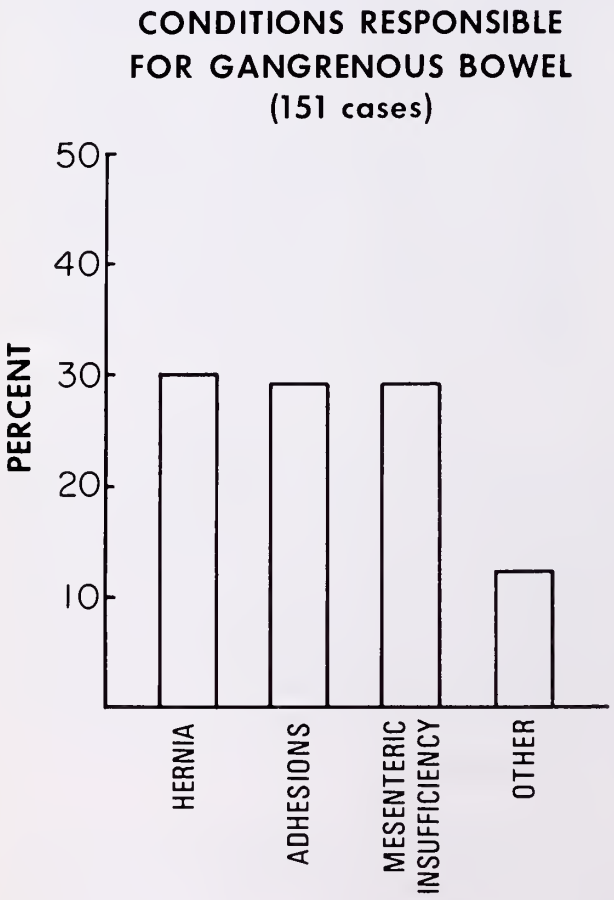


Figure 1. Relative frequency of various etiologic agents.

Hernias and adhesions, as etiologic agents for gangrenous bowel, afford more opportunities for improvement in survival rate. They were responsible for about 60 per cent of the cases in the entire series.

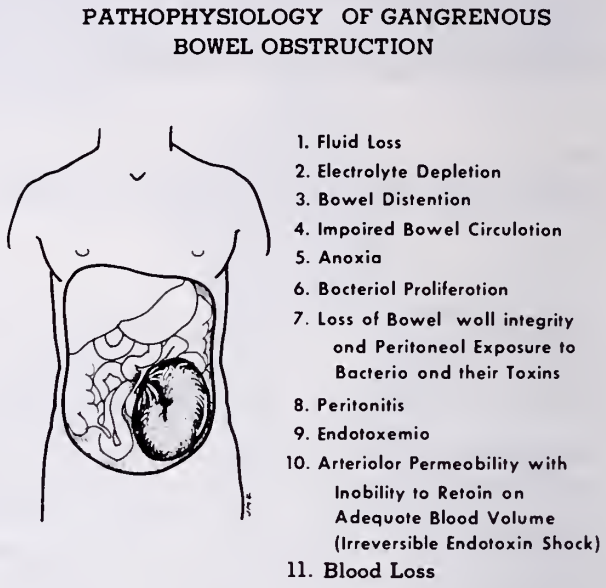


Figure 2. Adverse changes which affect body physiology.

The Diagnosis. Diagnosis of complete bowel obstruction usually poses no significant challenge to a competent physician. To establish the presence of bowel circulatory compromise preoperatively is a troublesome, frequently inaccurate venture. Findings which may be suggestive include continuous, unrelenting abdominal pain, shock, bloody bowel movement, localized abdominal enlargement, palpable mass, direct and rebound tenderness, aspiration of bloody fluid from the peritoneal cavity, leukocytosis and fever. In spite of these considerations, it is well to remember that there are no absolute criteria by which the presence of bowel gangrene can be established preoperatively in all cases.

Early Operation. Because of the dangers of expectant observation and the inaccuracies of clinical signs, I am persuaded that a deliberately planned course of preoperative preparation and operative relief of the obstructing mechanism should be followed in virtually all cases. This approach will provide relief where gangrenous bowel is suspected and also expose the occult case (see Figure 3). We found fatal delays in providing surgical relief to occur at three levels. In many instances, the patient was responsible for late consultation with a physician. In other circumstances, the physician who initially saw the patient was responsible. Some cases experienced fatal delays in referral centers.

Dependence Upon Nasogastric Suction for Definitive Relief. In those cases where complete intestinal obstruction exists, I am of the opinion that it is a mistake to defer surgery in favor of nasogastric suction. The latter represents a most helpful ancillary maneuver but may allow the subtle development of gangrene as operative intervention is postponed. I would heartily endorse its use in partial obstruction, paralytic ileus, obstruction from localized peritonitis, and in the unusual circumstances of multiple recurrent obstruction. At least four patients in our series were lost because of delay secondary to prolonged nasogastric suction.

Optimal Preoperative Preparation. The patient with gangrenous bowel obstruction suffers from all the pathophysiologic changes characteristic of simple obstruction plus two additional ones, blood loss and exposure to bacteria and their toxins (see Figure 2). Optimal preoperative restoration of adequate fluid and electrolyte levels constitutes one of the major therapeutic modalities responsible for the enormous improvement in survival among patients with simple obstruction which has occurred during this century. Many older patients necessitate digitalization in order to adequately cope with the rapid infusion of large volumes of fluid. Intense antibiotic coverage must be utilized. During considerable experience with experimental strangulation obstruction, we were never able to reverse hypotension resulting from bowel gangrene without the administration of blood.[2]

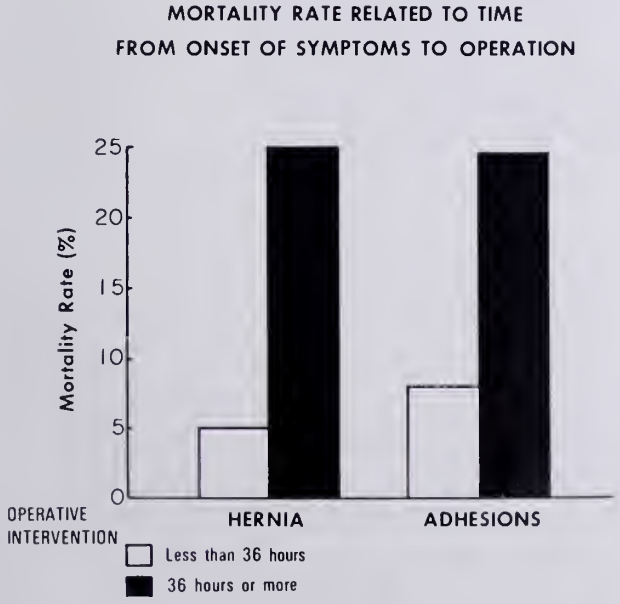


Figure 3. The keystone to improved survival rates currently resides with early operative intervention after optimal preoperative preparation.

Operative Techniques. Surgical maneuvers executed during the intraopertive period of management will continue to strongly influence the postoperative course and chances for recovery. After the abdomen is opened, all black fluid should be aspirated immediately. The gangrenous loop should be withdrawn upon the abdominal wall as soon as possible. Then, it is helpful to thoroughly irrigate the peritoneal cavity until saline returns as clear as when placed in the abdominal cavity. One need not fear the passage of strangulation fluid into normal segments of bowel after release of the obstructing mechanism. The normal mucous constitutes an effective barrier against absorption of these toxins, in contrast to the peritoneum.

Technical Errors. Inadvertent laceration of the obstructed, dilated, thin bowel wall with emptying of its toxic contents into the peritoneal cavity constitutes a major deterrent to chances for recovery. One must also guard against anastomotic errors such as ischemia, hematoma, stenosis and leakage.

Length of Resected Bowel. Among the cases reviewed, resection of larger loops of bowel entrapped by hernia or adhesions was followed by a better survival rate. This can probably be explained by severe symptoms resulting from blood loss with hypotension and earlier surgical intervention. Shorter loops produced less dramatic symptoms and so operation was initiated later in the course of the illness. Shock under the latter circumstance results from endotoxin exposure and reversal is much more difficult to achieve.

Postoperative Care. Among the 151 cases of bowel gangrene in our series, fatal complications occurred during the postoperative period which, of course, rendered all previous good care for naught. One patient died of a perforated peptic ulcer. Two patients exhibited fatal recurrent gangrene, apparently from propagation of a thrombus in the mesenteric veins. Postoperative intraabdominal hemorrage was responsible for an additional demise. Admittedly, the prompt diagnosis of such catastrophes during the early postoperative period poses a severe challenge. There is great reluctance on the part of the surgeon to move back to the operating suite during the postoperative period, but in some cases this represents the only hope for patient survival.

Age. Among our patients, the mortality rate was much greater in patients above 50 years of age. This was especially true in the adhesion and hernia cases. The ravages of severe pathophysiologic onslaughts are withstood more successfully among the lower age groups. The mortality rate in a given series will be

materially influenced by the number of patients over 50 years of age.

Late Pathophysiologic Changes. Much of the mortality in gangrenous bowel obstruction relates to irreversible changes resulting from endotoxin exposure. The arteriolar walls lose their integrity and leak fluid from the vascular system into the interstitial spaces. Recurring hypotension and oliguria, which are only temporarily responsive to volume restoration, along with weight gain, characterize the downhill course. No therapeutic agent is currently available which is effective in reversing this process. Therefore, operative removal of the gangrenous bowel must be carried out before this stage is reached.

Achievable Mortality Goals. The mortality rate among patients with bowel gangrene resulting from mesenteric insufficiency will probably remain high, in the 70 to 80 per cent range, for years to come. In the management of gangrenous obstruction from adhesion, the achieved mortality of 23 per cent could probably be lowered to less than 10 per cent if the above mentioned guidelines could be totally implemented. The same is true for hernia. ★★★

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Among children under five, lung diseases account for 33,400 deaths a year—nearly 20,000 in the first month of life. The American Lung Association and its state affiliates are working to help protect America's greatest resource through research and medical education programs. The Mississippi Lung Association also urges protection of children's lungs to health threat of second-hand smoke.

The First Three Years of Blood Pressure Screening by Mississippi Heart Association

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HYPERTENSION is the most common adult chronic disease in the United States. As such, it represents a staggering public health problem. According to the National Health Survey[1] the disease affects over 23 million Americans. In 1976, there were over 54 million patient visits for hypertension and hypertensive heart disease, representing the largest number of visits for any disease.

Much progress has been made in the ability to control this disease, especially when the therapy of 40 to 50 years ago is considered. Only recently have pharmacological agents of proven efficacy become available for the treatment of hypertension. Fortunately, the results have been very favorable. Support for the efficacy of modern pharmacological therapy exists in demonstrated outcome measures of lowered systolic and diastolic blood pressures, and more importantly, in significant decreases in morbidity and mortality.[2, 3] Well-designed studies have shown that through proper control programs the morbid and fatal effects of untreated hypertension can be drastically reduced.[4, 5]

We must be cautious in our enthusiasm, however, in light of reports that a majority of hypertensive individuals are undiagnosed, untreated and/or inadequately treated.[6–8]

Wilber and Barrow,[9] for example, found that in a random sample of persons in a Georgia community, 42 per cent of the 630 patients in the sample had elevated blood pressures but were unaware of it. Furthermore, only 30 per cent of those patients who were aware of their conditions were under treatment, and only about half of the treated group were judged to be under good control. After an intensive followup program was instituted the percentage judged to be under good control was raised dramatically to 80 per cent. Two years after the intensive followup program was discontinued, however, only 24 per cent remained under good control. The investigators concluded that the patients lacked a proper understanding of their disease state and that the primary factor contributing to their failure to remain under good control was their failure to take their medications.

The author discusses the accomplishments of the first three years of the Mississippi Heart Association High Blood Pressure Screening Program. During this period approximately 100,000 persons were screened for HBP at industrial and community settings using volunteer lay and professional personnel. Detection, referral and followup of hypertensive individuals are discussed, including effectiveness of the program in terms of continued lowered blood pressures of those who were referred to physicians, diagnosed as hypertensive and placed under treatment.

The last study illustrates several needs which effective intervention might help to satisfy:

1. There is a need for identification of previously undiagnosed hypertensive patients.
2. Once identified, treatment of these newly diagnosed hypertensive patients is needed.
3. There is a need for continuous followup care once the patient is diagnosed and stabilized.
4. Education of the patient concerning his disease state is needed.
5. Continuous monitoring of the patient's drug therapy regimen is necessary.

It is within this context that the Mississippi Heart Association (MHA) initiated its High Blood Pressure Screening Program. The goal of the program was to establish a pattern of excellence in blood pressure screening, referral and followup primarily among persons in industrial screenings. It sought *di-*

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rectly to identify previously undiagnosed potential hypertensive patients ("suspicious positives") and to refer them to their private physicians for further evaluation and treatment (when indicated). Furthermore, the program *indirectly* sought to stimulate continuous followup (including monitoring of the prescribed medical regimen) and patient education by encouraging the patient to enter the medical care system. Although the primary target population was industrial employees, general community screenings were conducted as well.

Initiated by a "seed grant" from the American Heart Association Program Development and Demonstration Fund in July 1972, the project has received further financial support by Memphis and Mississippi Regional Medical Programs and Mississippi Heart Association funds. By June 30, 1977, over 230,000 persons had been screened for high blood pressure through this program. The remainder of this discussion will focus on the approximately 100,000 persons who were screened through June 30, 1975.

The uniqueness of this program lies in its effective use of voluntary health professional personnel and the *total* involvement of the MHA structure down to the "grass roots" level. MHA core staff coordinated the screenings, but the health professionals who took blood pressure measurements were volunteers from the community.

The state was divided into three geographical areas (north, central, south) with a Program Implementer (PI) assigned to each area. Specific designation of the three areas was based on consideration of MHA district structure (there are 14 MHA districts in the state), geographic size, population density and industrial density.

The PI contacted management of industries in an effort to obtain their permission to screen their employees for hypertension. Upon receiving management approval, under the stipulation that medical data with respect to any given employee had to be kept strictly confidential and that MHA could reveal the findings only to the patient's physician, the procedures began.

Several days prior to the screening the Program Implementor arranged through the volunteer county Heart Association High Blood Pressure Chairman to have voluntary persons participate in conducting the screenings. Lay volunteers helped in the clerical tasks involved and health professionals (most often nurses and/or nursing students) took BP and pulse measurements. Screenees were asked to complete a brief questionnaire which contained items pertaining to patient demographic characteristics and medical history of hypertension.

During the screening, those persons who initially had a systolic blood pressure of 160 mm Hg or higher and/or a diastolic measurement of 95 mm Hg or higher were designated "suspicious positives." These persons were re-checked by a registered nurse or physician (who was a voluntary member of the screening staff). If the elevated blood pressure was verified, the suspicious positive was referred to his/her physician for further diagnosis and treatment. Each person was counseled concerning the importance of followup to see their physician and the importance of continuous care. Written information regarding high blood pressure and its control was also provided to each suspicious positive.

Finally, each potential hypertensive screenee was requested to take a postcard to the physician which requested him to provide MHA with information pertaining to whether he diagnosed the patient as hypertensive and whether the patient was placed under medical management.

At the conclusion of each screening, management was provided with a report of results of the screening effort. This included summary statistics with respect to number of persons screened, number of "suspicious positives" detected and a breakdown of "suspicious positives" by sex, race and whether they had been previously detected.

Thirty days after the screening a reminder letter on MHA Letterhead was sent to all persons who had not yet followed up to see their physician (as indicated by non-return of the physician postcard). This reminder letter stressed the importance of followup to the patient's health. If after 60 days the patient had not seen his physician a second followup letter was sent to the patient. Finally, if the patient had not seen his physician by the 90th day following the screening, he was contacted by a personal telephone call from a local county MHA volunteer.

During these screening efforts 4,301 nurses (and nursing students), 1,785 non-professionals and 353 physicians donated 13,676, 6,202 and 779 hours respectively during the first three years of the program. As can be noted above, the nurse-volunteers served as the backbone of the professional persons who donated time. Without their contributions the cost-efficiency of these high blood pressure screening efforts would have been drastically compromised.

From the inception of the program until June 30,

1975, almost 100,000 persons were screened. Industrial screenings accounted for 59.65 per cent of these screenees; the remainder were from community screenings. Table I provides a description of the population screened.

Several similarities and differences with respect to the two types of screenings may be noted. Persons screened at the community screenings included a larger percentage of individuals at the extremes of the age groups. A larger proportion of very young and very old individuals were present for community screenings than for those conducted at industrial settings.

Community screenings also contained a much higher proportion of individuals who had evidence of prior or existing HBP. Community screenees were more likely to report prior or present hypertension, prior or present medications or weight reduction diet for HBP, or present low salt diet for HBP. These indicate that a degree of self-selection bias may exist in the community population. That is, the community population contained a larger percentage of persons who knew they had hypertension and who were checking to see if their HBP were under control, rather than to see if they were part of the previously undetected hypertensive population.

The industrial population was characterized by a larger population of smokers (37.5 per cent) when compared to the community population (26.7 per cent). The two groups were similar, however, with respect to sex and race.

Figure 1 indicates that 5,451 (9.1 per cent) of the industrial screenees were referred to a physician for followup diagnosis and treatment, while 4,624 (11.5 per cent) of the community screenees were referred. This represented a total of 10,075 (10.1

TABLE I

DESCRIPTION OF POPULATION SCREENED*

Category		*Industry (N=59,604) No./(%)*	*Community (N=40,324) No./(%)*	*Total (N=99,928) No./(%)*
Age	0-14	38(0.1)	1,075(2.7)	1,113(1.1)
	15-24	13,571(22.8)	11,389(28.2)	24,960(25.0)
	25-34	15,927(26.7)	5,365(13.3)	21,292(21.3)
	35-44	11,953(20.1)	4,766(11.8)	16,719(16.7)
	45-54	10,403(17.5)	5,486(13.6)	15,889(15.9)
	55-64	5,570(9.3)	5,530(13.7)	11,100(11.1)
	65++	762(1.3)	5,362(13.3)	6,124(6.1)
Sex	Male	29,323(49.2)	18,297(45.4)	47,610(47.6)
	Female	30,285(50.8)	22,020(54.6)	52,305(52.3)
Race	White	40,680(68.3)	26,660(66.1)	67,340(67.4)
	Non-White	17,127(28.7)	12,062(29.9)	29,189(29.2)
Prior HBP	Yes	9,733(16.3)	10,311(25.6)	20,044(20.1)
	No	49,665(83.3)	29,800(73.9)	79,465(79.5)
Prior HBP medications	Yes	6,738(11.3)	7,963(19.7)	14,701(14.7)
	No	52,515(88.1)	32,070(79.5)	84,585(84.6)
Prior diet	Yes	3,067(5.1)	3,342(8.3)	6,409(6.4)
	No	55,899(93.8)	36,265(89.9)	92,164(92.2)
Smoking	Yes	22,326(37.5)	10,758(26.7)	33,084(33.1)
	No	36,800(61.7)	29,140(72.3)	65,940(66.0)
Present HBP	Yes	3,326(5.6)	4,571(11.3)	7,897(7.9)
	No	52,041(87.3)	30,751(76.3)	82,792(82.9)
Present medications for HBP	Yes	3,520(5.9)	5,164(12.8)	8,684(8.7)
	No	55,325(92.8)	34,331(85.1)	89,656(89.7)
Present low salt diet	Yes	2,099(3.5)	2,940(7.3)	5,039(5.0)
	No	56,869(95.4)	36,650(90.9)	93,519(93.6)
Present weight reduction diet	Yes	3,400(5.7)	3,333(8.3)	6,733(6.7)
	No	55,269(92.7)	36,925(89.1)	91,194(91.3)
Referred to physician	Yes	5,451(9.1)	4,624(11.5)	10,075(10.1)
	No	54,153(90.9)	35,700(88.5)	89,853(89.9)

* Totals may not equal 100% due to missing data.

per cent) persons referred. Among industrial screenings, 3,676 (67.4 per cent) "suspicious positives" went to their physician for further evaluation. Medical management was necessary for 2,417 (74.1 per cent) of those who visited their physician.

Similar relationships were found among community screenees. Among those screened at community settings, 3,304 (71.5 per cent) followed up with visits to their physicians. From this group 2,145 (75.9 per cent) were placed under medical management for hypertension.

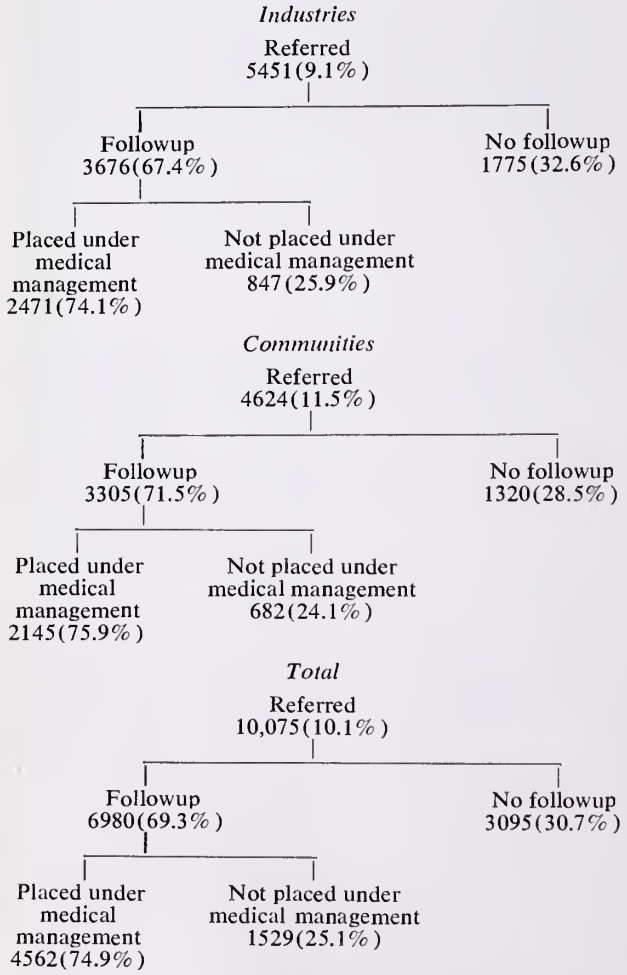


Figure 1. Followup to physician by type of screening.

Finally, the time elapsed between screening and followup provides some insight (as a process indicator) to the effectiveness of the program. Table II indicates that among those who did follow up to see their physician, 3,066 (44.9 per cent) did so within 15 days. This figure fell dramatically to 504 (7.4 per cent) during the next 15-day period. During the following thirty days, 1,359 (19.9 per cent) followed up to visit their physician. This figure dropped slightly to 780 (11.4 per cent) during the next 30 days only to rise slightly again after this period to 1,115 (16.3 per cent) persons.

The above figures seem reasonable, given the protocol for the program. One would expect a relatively large percentage of screenees to visit their physician immediately upon learning that they were (potential) hypertensive patients. The rise during the period 31-60 days occurred after the first followup letter to the screenee reminding him/her to see his/her physician. A second contact (in the form of a letter) at day 60 resulted in a somewhat smaller number of persons contacting their physician. Finally, at day 90 contact by a personal phone call to encourage the screenee to visit his physician resulted in a rise in the number of persons who reported contacting their physician.

In order to determine the effect of the program in terms of continued lowered blood pressures among hypertensive screenees an evaluation of the screening efforts was conducted in a limited (three county) area which included 236 persons who had been referred to their physician. A second screening conducted from one to two years later served as the vehicle for the evaluation. Methods and results of the evaluation are presented more fully in another report.[10] However, the findings of this investigation are summarized below.

Among the persons referred to a physician at the initial screening 77 (59.2 per cent) of the industrial and 68 (65.4 per cent) of the community screenees were judged to have their high blood pressure under control at the evaluation screening, which was conducted from 10 to 25 months later. Thus 145 (61.44 per cent) persons who had been referred to a physician at the first screening were under control at the second screening. This stands in remarkable contrast to other much less successful efforts reported in the literature.

Surprisingly, almost all variables examined in relation to referral status (at the second screening) showed no statistically significant relationships. These included variables with respect to patient demographic characteristics, HBP history, knowledge about HBP and its treatment and symptom experience. Similarly, few variables were significantly related to self-reports of compliance to medication regimens.

Two important relationships did emerge, however, which are central to the tenets of the program. First,

TABLE II

DAYS ELAPSED BEFORE FOLLOWUP BY TYPE OF SCREENING

Type of Screening	*1-15 No.*/(%)*	*16-30 No./(%)*	*31-60 No./(%)*	*61-90 No./(%)*	*Over 90 No./(%)*
Industry	1689(47.0)	248(6.9)	718(20.0)	391(10.9)	546(15.2)
Community	1377(42.6)	256(7.9)	641(19.8)	389(12.0)	569(17.6)
Total	3066(44.9)	504(7.4)	1359(19.9)	780(11.4)	1115(16.3)

* Represents number of screenees who were in this category.

those who did indeed follow up to see their physician as a result of the initial screening were significantly more likely to have their hypertension under control at the second screening. Among those who did not follow up, 76 per cent were referred to a physician at the second screening; only 41.5 per cent of those who *did* follow up as a result of the initial screening were referred to their physician at the evaluation screening.

Another important relationship existed between compliance and HBP control. Only 28.7 per cent of persons who reported compliance to their medication regimen were referred to a physician at the evaluation screening. Among the noncompliers, 76.5 per cent were not on a normotensive status at this second screening.

The Mississippi Heart Association has established a unique program of mass screening for hypertension based upon efficient coordination of health professionals and lay persons who provide their services as volunteers. This basis of voluntary manpower has provided a cost-efficient (costs for this program are estimated to be $1.77 per screenee) and effective mechanism for identifying potential hypertensives and insuring their entry into the medical care system.

The Mississippi Heart Association has attempted to act as a catalyst in this program to draw interested groups together, establish and coordinate an efficient and effective program and then encourage other existing resources to carry on with the efforts. A model program has been established which others can easily utilize in efforts toward effectively screening for hypertensive individuals. ★★★

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MSMA Annual Session ★ May 1-4, 1978 ★ Jackson

Radiologic Seminar CLXXVII: Radionuclide Bone Scanning in the Diagnosis of Acute Osteomyelitis

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When osteomyelitis is clinically suspected, the radionuclide bone scan may be a decisive diagnostic procedure. It is definitely more sensitive than radiographic evaluation. The scan can be positive as early as 24 to 48 hours after onset of clinical symptoms, and 10-14 days prior to radiological changes.

In the past decade, technetium-99m labeled phosphate compounds have replaced strontium-85 and are now the most widely used radiopharmaceuticals. Advantages are significantly increased count rates and faster examination. Waiting times from injection to scanning have been drastically shortened from several days to about three hours. Radiation dose has been reduced to safe levels comparable with conventional radiographic studies. Evaluation of nonmalignant disorders is feasible in both adults and children.

Clinical Setting and Advantages. The clinical presentation of malaise, fever and localized pain with or without point tenderness should lead one to consider the possibility of acute osteomyelitis. Early diagnosis and prompt initiation of the appropriate antibiotic treatment results in reduced morbidity and prevention of chronic bone changes. Definitive diagnosis is not always easy. In one series, 45 per cent of 42 patients diagnosed as having osteomyelitis never developed radiographic evidence of the disease. The radionuclide bone scan is especially useful when the early administration of antibiotics for a "fever of unknown origin" has masked the symptoms of osteomyelitis. It can also be used to accurately localize a lesion when surgical drainage is required.[2] If the suspected abnormality is in the axial skeleton, including the spine and pelvis, it is quite difficult to evaluate by conventional radiography; the radionuclide bone scan is an especially valuable diagnostic tool for evaluation of these areas.[5]

The addition of a blood pool scan obtained immediately after radionuclide injection is gaining in popularity. It is especially useful in differentiating acute osteomyelitis from cellulitis.[5] This differentiation is important because the differential diagnosis is often difficult, and the management is somewhat different.

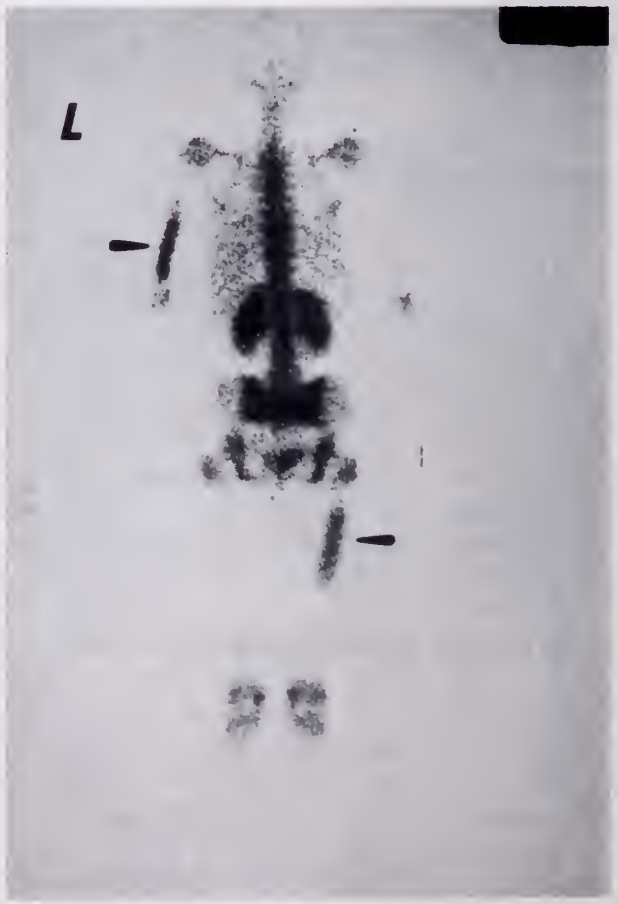


Figure 1. Posterior bone scan in a 28-year-old female with abnormal uptake in the left humerus and right femur. Blood cultures were positive for Salmonella.

Sponsored by the Mississippi Radiological Society.
From the Division of Nuclear Medicine, Department of Radiology, University of Mississippi Medical Center, Jackson, MS.

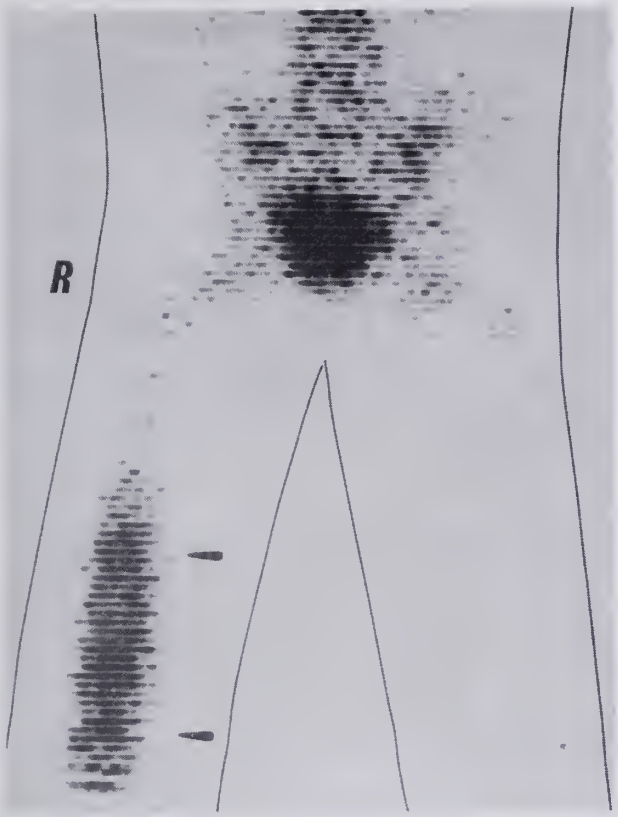


Figure 2. Posterior bone scan in a five-year-old child with abnormal uptake in the shaft of the right femur. Cultures of blood and drainage site were positive for Klebsiella.

Scan Findings and Differential Diagnosis. In osteomyelitis, typical findings are a focus of increased radioactivity in the scan, occasionally superimposed on a diffuse area of increased radioactivity secondary to generalized hyperemia. The immediate blood pool image shows only a diffuse area of hyperemia.[5]

The typical appearance of cellulitis is a diffusely increased area of radioactivity seen on both the early blood pool and bone image but without a focal component.[3, 5] The early scan is normal in proven bone infarction due to sickle cell crisis. There is either decreased or slightly increased uptake on the delayed scan. In these patients radiographs can demonstrate previous bone infarction, but may be normal or show only soft tissue swelling.[4]

In acute transient synovitis or hematogenous pyogenic joint disease, bone scanning is usually normal when performed early in the course of the disease.[1]

All patients with normal early and delayed scans in a series of 46 patients scanned for suspected soft tissue or osseous inflammatory disease had no ischemic or inflammatory disease on clinical and laboratory followup.[4]

Limitations. When bone scanning is done earlier than 24-48 hours after onset of clinical symptoms, the study may be normal. A repeat examination should be done if clinical symptoms persist and osteomyelitis is suspected.[1]



Figure 3. Anterior bone scan in a 13-year-old male with abnormal uptake in the right tibial shaft, and to a lesser degree in the left femur and left tibia. The patient presented with fever, limp, and right leg pain, and responded to antibiotic therapy.

Bone scanning is not an accurate means for evaluating the response to treatment in the immediate followup period.[2] Frequently there is persistent increased uptake in the involved area for up to six months, even after complete clinical recovery.[2] However, correlation of regressive or progressive changes on serial scans is often helpful.[1]

Hyperemia and increased metabolic activity in areas may cause an "extended pattern" of extralesional uptake. This should be considered when there is evidence of regional hyperemia, and when the area of radionuclide uptake does not correspond to the clinical extent of the disease.[1, 6]

Summary

The radionuclide bone scan is often a definitive diagnostic tool in the clinical setting of acute inflammatory osseous disease. Early diagnosis enables initiation of appropriate treatment that prevents most chronic crippling bone defects. The procedure is simple, safe, and effective. ★★★

2500 North State Street (39216)

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OATH OF HIPPOCRATES

I swear by Apollo the physician, and Aesculapius, and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgment, I will keep this Oath and this stipulation—to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to any one if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practice my Art. I will not cut persons laboring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, of freemen and slaves. Whatever, in connection with my professional practice or not, in connection with it, I see or hear, in the life of men, which ought not be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times! But should I trespass and violate this Oath, may the reverse be my lot!

POSTGRADUATE CALENDAR

Feb. 8-10, 1978
NEWBORN SEMINAR FOR THE PHYSICIAN
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics, Division of Newborn Medicine; and the University Medical Center Division of Continuing Health Professional Education.

Coordinator: Gwendolyn Bussa, M.N., assistant professor of nursing, University of Mississippi School of Nursing, and instructor in obstetrics-gynecology, University of Mississippi School of Medicine.

This three-day course is designed for general practitioners, family physicians, obstetricians and pediatricians. Topics to be discussed include gestational age assessment, respiratory disease, hyperbilirubinemia and genetics. Fee $75.00. Credit: 19 contact hours, 1.9 CEU, Category I AMA; AAFP credit applied for.

Feb. 15, 1978
HYPERTENSION SEMINAR
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine and the University Medical Center Division of Continuing Health Professional Education with support from Pfizer, Inc.

Coordinator: Herbert G. Langford, M.D., professor of medicine, University of Mississippi School of Medicine.

Designed for the general practitioner, this one-day seminar will emphasize advances in the treatment of hypertension. There will be a fee. AMA Category I and AAFP credit will be applied for.

Mar. 9-11, 1978
SURGICAL FORUM V
Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Surgery, and the Medical Center Division of Continuing Health Professional Education.

Coordinator: James D. Hardy, M.D., professor of surgery and chairman of the department, University of Mississippi School of Medicine; and William O. Barnett, M.D., professor of surgery, University of Mississippi School of Medicine.

An international guest faculty will lead this postgraduate seminar for general surgeons. Subjects to be discussed include surgical management of obesity, management of hyperthyroidism, splenectomy and management of Hirschsprung's Disease. Attendance is by invitation and advance registration is required. Fee: $150.00. Credit: 17 contact hours, 1.7 CEU, Category I, AMA.

FUTURE CALENDAR

Mar. 15-17, 1978
NEWBORN VENTILATION
University Medical Center, Jackson

Mar. 20-31, 1978
NEWBORN CARE FOR THE PHYSICIAN AND NURSE TEAM
University Medical Center, Jackson

Mar. 30-April 1, 1978
GASTROENTEROLOGY UPDATE
Ramada Inn Coliseum, Jackson

April 6-7, 1978
SOUTHEASTERN REGIONAL FACULTY DEVELOPMENT WORKSHOP
Holiday Inn Medical Center, Jackson

April 13-14, 1978
NEWBORN RESUSCITATION
University Medical Center, Jackson

May 1-4, 1978
MSMA ANNUAL SESSION
Coliseum Ramada Inn, Jackson

May 11-12, 1978
NEWBORN NUTRITION
University Medical Center, Jackson



The President Speaking

Some New Year's Resolutions

JAMES O. GILMORE, M.D.
Oxford, Mississippi

THIS IS THE customary time to reflect about the New Year and to make some resolutions. I had some thoughts on this which I would like to share with you.

My first resolve for 1978 is to have the public we serve better understand that there is no such thing as a "free lunch" as far as quality health care is concerned. The "right" to adequate health care can not mean the best health care for all our citizens unless the best is to be less than we know and expect health care to be today. The "right" to adequate housing and food does not mean a mansion and gourmet meal for every citizen and somehow we must qualify the "right" to health care in the same way.

Parenthetically, it is my hope that we as physicians will resolve to better understand and assume our obligation to participate in those public forums where decisions about adequate health care are being made. Let's not leave these decisions to health planners who may know how to add health budgets and count people and hospital beds but have no responsibility for the effect of their decisions on individuals in need of medical care.

My next resolve is that we better appreciate the purpose of our local society, MSMA and AMA. For better (or worse) these organizations only reflect our collective goals as a profession. If you don't like what your local society, MSMA or the AMA is doing (and oftentimes personally I don't) then don't stand on the outside throwing rocks like they are some foreign beings from Mars. Pogo said it better, perhaps, to the effect that we have met the enemy and it is us. Let's get in there and participate and seek the changes we want! Remember, however, that these organizations, as well as all other democratic organizations, must reflect the majority view.

My final and greatest resolve for the New Year is that our profession, which I quite willingly assume is the greatest in the world, will continue to grow in stature and in those good things which it can do for mankind. There are two principles or ideals of our profession that particularly come to mind when I make this assumption and express this resolve. They are . . . "The principal objective of the medical profession is to render service to humanity. . . ." and . . . "The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual but also to society. . . ."

Let's recommit ourselves to these principles in 1978 and surely it will be a good year for our patients and our profession. ★★★

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XIX, NUMBER 1
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AAMA-Mississippi Society

Fellow physicians, do you know that there is an association for medical assistants in Mississippi? The Mississippi Society, Inc., a constituent society of the American Association of Medical Assistants, Inc., was chartered in 1965 at the National AAMA Convention in New York City, and has since then grown to a society of 14 chapters and approximately 400 members. This association is a nonprofit organization which shall not ever become a trade union or collective bargaining agency.

The AAMA-MS is a professional society for medical assistants, secretaries, nurses, technicians, bookkeepers, receptionists in doctors' offices or medical facilities supervised by a physician, and students who are enrolled in an accredited medical assisting program in a school.

"To be an effective member of the health care team, a proficient medical assistant must keep up to date and in tune with the changing times. Her knowledge of new procedures and advances in medicine should keep pace with yours." Members of the AAMA-MS, therefore, participate in organized educational activities—planned meetings, study groups, lectures, continuing educational programs and workshops.

Annual state conventions and educational symposia offer a variety of educational sessions, including latest developments in health care field. Mississippi medical assistants represent your state at national AAMA annual conventions. (See article in this issue of MSMA recognizing the award won by Mississippi at the 1977 national convention.) Several members of the AAMA-MS serve on national committees. There are some Mississippi physicians who serve the medical assistants society on the AAMA National level.

AAMA-MS members exchange profcssional ideas with one another thus broadening the scope and effectiveness of medical assisting. Your employee will make many new friends in her/his field when conferring on mutual problems. Encourage your medical assistant to become an active member of this outstanding organization. Enroll your medical assistant employee today in AAMA. Annual dues—local, state and national—are a minimal $30.00. Contact the AAMA-Mississippi Society president, Mrs. Peggy Long, at 1725 Apple Lane, Clarksdale, MS 38614 for additional information.

"Remember, a medical assistant is more than a career girl . . . she is an efficient humanitarian who lengthens and strengthens the healing arm of the physician. . . ."

Myron W. Lockey, M.D.
Associate Editor

Medico-Legal Brief

The Bakke Case

The Supreme Court has requcsted lawyers for both sides in the Bakke "reverse discrimination" suit to file an additional brief explaining how the 1964 Civil Rights Act may affect a ruling in this casc.

Thc request from the bench is viewed by somc observers as a sign that the justices are considering making a very narrow ruling rather than a broad constitutional interpretation in the casc brought by Allan Bakkc, a 37-year-old white male who claims that he was unconstitutionally denied admission to the University of California Medical School at Davis, while 16 less academically prepared minority students were admitted.

The 1964 law is the cornerstonc of the nation's Affirmativc Action program, which generally has becn used by federal agencies as a legal mandatc to require busincss, industry and educational institutions to sct standards and goals for increasing minority participation in thcir fields. Thc law also includes a provision that bars race discrimination in

any federally assisted programs—including federally supported medical institutions.

At issue in the Bakke case is the question of whether the Davis minority admissions program, in reserving 16 of 100 seats for minority students, set what amounted to an illegal quota.

In opening arguments before the court, Reynold H. Colvin, Mr. Bakke's lawyer, said, "Here we have a quota where the number is first chosen and then the number is filled regardless of the standard." Although the university maintains that all minority students admitted were fully qualified, Mr. Colvin said that "we certainly do dispute" that contention.

But Harvard professor Archibald Cox, former U. S. Solicitor General and special Watergate prosecutor, countered by saying that the 16 reserved places were "certainly not a quota in the older sense —put on members of an unpopular group to keep them out."

"It doesn't say to any group, 'you are inferior,' " he said. "There is no racially blind method of selection which will enroll more than a trickle."

PERSONALS

EMIL AFTANDILIAN of Senatobia has been elected chief of staff of the Senatobia Community Hospital.

LARRY AYCOCK of McComb has been elected chief of the medical staff at Southwest Mississippi Regional Medical Center. HENRY SANDERS was elected secretary and TOM CAREY was named chief of staff-elect.

HUGH P. BROWN of Jackson attended the International Scoliosis Research Society meeting in Hong Kong where he presented a paper, "Surgical Management of Congenital Kyphosis in Myelomeningocele —A Preliminary Report on a New Two-Stage Procedure."

HILTON M. FAIRCHILD announces the removal of his office to the Walnut Grove Medical Clinic, Pine Street, in Walnut Grove for family practice.

The Hattiesburg Clinic Professional Association announces the association of H. ALLEN GERSH and KENNETH J. GAINES. Dr. Gersh will practice internal medicine and nephrology and Dr. Gaines is a neurologist.

WILLIAM L. HALL has joined the staff of the Lucius Olen Crosby Memorial Hospital for the practice of internal medicine. He will be associated with DONALD R. BERRY at Berry Clinic, 622 Goodyear Boulevard in Picayune.

LARRY J. HAMMETT of Hattiesburg announces the opening of his new office at 206 South 28th Avenue for practice limited to diseases of the ear, nose, and throat.

JAMES D. HARDY of Jackson and UMC was among five University of Mississippi alumni inducted into the Alumni Hall of Fame during fall homecoming activities at Ole Miss.

F. J. HARRELL announces the removal of his offices to Medical Plaza Building, Office 202, 127 Lameuse Street in Biloxi.

Mississippi surgeons inducted into fellowship by the American College of Surgeons included DONALD A. HOPKINS of Gulfport, DEWEY H. LANE and RICHARD A. NICHOLLS of Pascagoula.

WILLIAM L. KAHLSTORF of Tupelo represented Mississippi on the Council of the National Perinatal Association in Louisville, KY in November. Dr. Kahlstorf is on the regional advisory board of the Southern Perinatal Association.

KELLY E. HUTCHINS has joined the staff at Jones County Community Hospital in Laurel as a pathologist.

ROBERT ASHFORD LITTLE of Gulfport has been elected president of the Coast Counties Medical Society for 1977-78.

MARTIN H. MCMULLAN of Jackson is a recent enrollee in the Medical Alumni Guardian Society of the University of Mississippi Foundation.

RICHARD W. NAEF, Jackson neurologist, discussed the emotional factors of epilepsy at the October meeting of the Mississippi Council on Epilepsy at St. Dominic Hospital in Jackson.

BHARAT R. PATEL has set up his family practice at the Medical Arts Building, 1203 Jefferson Street in Laurel. His wife, JAISHRI PATEL, is in family practice at New Augusta.

JOHN RAWSON of Jackson and UMC has been named statewide chairman of the National Foundation's March of Dimes fund drive to fight birth defects for the third consecutive year.

HARRY SALTZ of Osyka was honored with a reception at the city hall by Osyka residents to welcome his medical practice there.

W. E. "BILL" SUMNERS announces the relocation of the Children's Clinic to 404 Court Street in Booneville.

WILLIAM TRULY of Canton announces the opening of his new office for family practice at 120 N. Second Avenue.

NEW MEMBERS

ANDERSON, WILLIAM J., Jackson. Born Jackson, MS, Oct. 5, 1943; M.D., Vanderbilt University School of Medicine, Nashville, TN, 1969; interned Johns Hopkins, Baltimore, MD, one year; surgery residency, same, 1970-75; elected by Central Medical Society.

ANIS, ONSSY H., Jackson. Born Egypt, Dec. 14, 1935; M.D., Cairo University School of Medicine, Egypt, 1960; interned Jersey Shore Medical Center, Neptune, NJ, 1970-71; radiology residency, Albert Einstein College of Medicine, Bronx, NY, Jan. 1974-June 1975; radiology residency, Jamaica Hospital, NY, Jan. 1971-Dec. 1971; radiology residency, Hackensack Hospital, NJ, Jan. 1972-Dec. 1973; elected by Central Medical Society.

ARHELGER, ROGER BOYD, Jackson. Born Green Bay, WI, May 23, 1932; M.D., University of Minnesota Medical School, Minneapolis, 1958; interned Boston Public Health Service Hospital, Boston, MA, July 1958-June 1959; pathology residency, University Medical Center, Jackson, MS, 1959-62; elected by Central Medical Society.

BAZZONE, VICTOR T., Gulfport. Born McKeesport, PA, Dec. 22, 1939; M.D., University of Pittsburgh School of Medicine, Pittsburgh, PA, 1965; interned West Virginia University Hospital, Morgantown, WV, one year; general surgery residency Allegheny General Hospital, Pittsburgh, PA, 1969-70; neurosurgery residency, Presbyterian University Hospital, Pittsburgh, PA, 1970-74; elected by Coast Counties Medical Society.

CARTER, MICHAEL H., JR., Greenwood. Born Jackson, MS, Mar. 30, 1943; M.D., Tulane University School of Medicine, New Orleans, LA, 1969; interned Tulane and Charity Hospital, New Orleans, LA, 1969-70; otolaryngology residency, same, 1970-74; elected by Delta Medical Society.

DOOLITTLE, PHILIP DEXTER, Greenville. Born Richton, MS, Jan. 7, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned University Medical Center, Jackson, MS, one year; surgery residency, same, 1973-77; elected by Delta Medical Society.

GANARAJ, P. S., Tylertown. Born Perdala, India, Feb. 16, 1940; M.D., Kasturba Medical College, India, 1968; interned Government Hospital, Mangolore, India, one year; surgery residency, Worcester City Hospital, MA, 1970-71; surgery residency, St. Vincento Hospital, Worchester, MA, 1972-74; elected by South Central Medical Society.

JONES, BRUCE MCALPHIN, Columbia. Born Hattiesburg, MS, Sept. 14, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned Mobile General Hospital, Mobile, AL, one year; family practice residency, Medical Center, Columbus, GA, Jan. 1975-Dec. 1976; elected by South Mississippi Medical Society.

MAHALAK, LAWRENCE WARREN, JR., Jackson. Born Alexandria, LA, Jan. 12, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned U. S. Naval Hospital, Portsmouth, VA, one year; neurology residency, University Medical Center, Jackson, MS, 1973-76; elected by Central Medical Society.

MAYFIELD, WILLIAM CATO, JR., Jackson. Born Dyersburg, TN, June 27, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned Mississippi Baptist Hospital, Jackson, one year; ophthalmology residency, University of Alabama, and the Eye Foundation Hospital, Birmingham, AL, 1974-77; elected by Central Medical Society.

NUDURFT, JOSEPH H., Bay St. Louis. Born Lyons, KS, Mar. 6, 1923; M.D., University of Illinois College of Medicine, Chicago, 1948; interned Indiana University Medical Center, Indianapolis, one year; anesthesiology residency, same, 1959-61; elected by Coast Counties Medical Society.

NEW MEMBERS / Continued

PATEL, PRAVINCHANDRA P., Shelby. Born Uganda, East Africa, Jan. 29, 1948; M.D., Byramjee Jeejeebhoy Medical College, Poona, Maharashtra, India, 1975; orthopedic surgery residency, Black Notley Hospital, Braintree, England, Broomfield Hospital, Chelmsford, England and Whipps Cross Hospital, London, England, March 1975-June 1976; elected by Clarksdale & Six Counties Medical Society.

PETRO, ANTHONY BEDEAR, Jackson. Born Charleston, SC, Jan. 3, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned Vanderbilt University Hospital, Nashville, TN, one year; internal medicine residency, same, 1970-71; general surgery residency, University Medical Center, Jackson, MS, 1971-75; elected by Central Medical Society.

ROBINSON, GEORGE ROBERT, Gulfport. Born Laurel, MS, May 29, 1939; M.D., University of Mississippi School of Medicine, Jackson, 1968; interned University Medical Center, Jackson, MS, one year; internal medicine residency, same, 1969-72; elected by Coast Counties Medical Society.

ROBINSON, JOHN WARREN, Meridian. Born Meridian, MS, May 29, 1939; M.D., University of Mississippi School of Medicine, Jackson, 1965; interned Mississippi Baptist Hospital, Jackson, MS, one year; orthopedic surgery residency, University Medical Center, Jackson, MS, 1966-70; elected by East Mississippi Medical Society.

RUSSELL, ROBERT P., Jackson. Born Columbia, SC, April 30, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned Mississippi Baptist Hospital, Jackson, one year; ophthalmology residency, University Medical Center, Jackson, MS, 1974-77; elected by Central Medical Society.

SIMMONS, SUE H., Maben. Born Jackson, MS, Oct. 18, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1975; interned University Medical Center, Jackson, MS, one year; elected by Prairie Medical Society.

SMITH, PRENTISS L., Brookhaven. Born New Orleans, LA, Mar. 10, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned University Medical Center, Jackson, MS, one year; radiology residency, same, Jan. 1974-Dec. 1976; elected by South Central Medical Society.

STEVENS, WILLIAM WILSON, III, Jackson. Born Bremerton, WA, Sept. 27, 1945; M.D., Baylor College of Medicine, Houston, TX, 1971; interned Mississippi Baptist Hospital, Jackson, MS, 1971-72; ophthalmology residency, Mayo Graduate School of Medicine, Rochester, MN, 1973-76; elected by Central Medical Society.

VAUGHAN, THOMAS A. J., Jackson. Born Natchez, MS, Oct. 4, 1946; M.D., University of Texas Medical Branch, Galveston, TX, 1972; interned Scott & White Memorial Hospital, Temple, TX, one year; anesthesiology residency, Vanderbilt University Hospital, Nashville, TN, Aug. 1973-Feb. 1974; anesthesiology residency, University of Texas, Parkland Memorial Hospital, Dallas, TX, March 1974-Aug. 1975; elected by Central Medical Society.

WISER, WINFRED LAVERN, Jackson. Born Wartrace, TN, June 14, 1926; M.D., University of Tennessee College of Medicine, Memphis, 1952; interned John Gaston Hospital, Memphis, TN, one year; ob-gyn residency, University Medical Center, Jackson, MS, 1959-62; elected by Central Medical Society.

DEATHS

BASS, JAMES C., JR., Laurel. Born Jackson, MS, Jan. 4, 1923; M.D., University of Tennessee College of Medicine, Memphis, 1949; interned Lloyd Noland Hospital, Fairfield, AL, one year; surgery residency, District of Columbia Hospital, Washington, DC, 1953-56; died Nov. 14, 1977, age 54.

PEGUES, J. C., Greenwood. Born Scottsboro, AL, Sept. 2, 1892; M.D., Emory University School of Medicine, Atlanta, GA, 1923; EENT residency, Grady Memorial Hospital, Atlanta, GA, 1923-26; died Oct. 23, 1977, age 85.

WILDE, ADNA GODFREY, Biloxi. Born Saratoga Springs, NY, April 20, 1895; M.D., University of Virginia School of Medicine, Charlottesville, 1910; Emeritus member of MSMA and AMA; Fifty Year Club of MSMA; died Nov. 26, 1977, age 92.

Board of Trustees Holds Fall Meeting

The Board of Trustees held its regular fall meeting in Jackson on Dec. 15, 1977, and considered a full agenda of business to include the association's 1978 budget and reports on the AMA Clinical Meeting, the association's 1978 legislative recommendations, organization of the Mississippi Medical Fraternal and Educational Society, endorsement of Blue Cross-Blue Shield of Mississippi and the association's group insurance program.

The Board approved a 1978 association budget totalling $804,875.00 to include a net gain in association reserves of some $50,000 after transfer of AMA dues and operating expenses totalling $754,-000.00. The association's membership continued to grow during 1977 and dues income amounted to 72 per cent of total income.

The association's 1978 legislative recommendations as approved by the House of Delegates and recently furnished to each member were reviewed. These recommendations include a four point program to: (1) seek an increase in professional fees under the Medicaid program; establish statutory recognition of malpractice claim review panels; (3) establish programs of segmented health education in the state's public school; and (4) prohibit age discrimination in employment.

MSMA's delegates to the recent AMA Clinical Meeting presented a report covering actions at the meeting noting in this regard that the AMA had gone on record in support of more equitable Medicare payments to physicians locating in rural areas and voted to continue to support a comprehensive health insurance program covering all Americans.

Activities to organize the Mississippi Medical Fraternal and Educational Society were reported to the Board and it was noted that the society was now operational with some 200 policies issued to its 800 members over the past several weeks.

The Board considered reports on the association's endorsement of Blue Cross-Blue Shield of Mississippi and went on record to recommend endorsement to the MSMA House of Delegates at the 1978 annual session.

The Board also heard a report from the administrator of the association's group insurance programs for members, Thomas A. Yates and Company of Jackson, noting improvements in these various programs which would be reported to the membership.

In other actions, the Board directed the association's attorneys to proceed in state court to resolve the Governor's illegal activities with respect to the State Board of Health; agreed to have the association join the Ole Miss Medical Alumni in investigating the feasibility of conducting a small community health professional recruitment program; and expressed its sympathy and interest in a suit filed by a physician on the Coast attacking discrimination in Medicare reimbursement policies for physicians' services.

Health Expenditures Rise in U. S.

Americans spent $120.4 billion for personal health care in fiscal year 1976.

This sum—an average of $552 per person—includes outlays for health and medical services for the direct benefit of the individual, and includes private as well as government payments.

Compare with the previous year's figure of $103.2 billion, this represents an increase of nearly 17 per cent, more than 2½ times the amount spent a decade ago. Individually, Americans spent $63 more in 1976 than they did in fiscal year 1975.

Social Security Administration data confirm the belief that the greatest chunk of health care dollars is spent by Americans 65 years of age or older. Their average outlay was $1,521 per person as compared with $249 for those under 19.

For persons 19 to 64 years of age, the average outlay was $547.

Hospital care again took the lion's share of personal health care dollars for persons in all age groups—45 per cent of the average outlay or $689 for those 65 or older, 49 per cent or $268 for those 19 to 64 years of age.

Taking the second largest slice of personal health care dollars was physicians' services. For Americans 65 or older, however, this represented only 17 per cent of $256 of their average outlay, compared with 23 per cent or $351 spent for nursing home care.

Medical Auxiliary Grants Nurse's Loan

Ms. Marie Crispin, R.N., of Jackson is this year's recipient of a loan of $500 from the Mississippi State Medical Association Auxiliary to assist in furthering her education and training in the field of nursing. She is currently attending the University of Mississippi School of Nursing and hopes to complete the requirements for a B.S. in Nursing in 1979. She plans to obtain a master's degree in psychiatric nursing and to teach in the field of psychiatric mental health.

The Nurse's Loan Fund is supported by contributions from the state medical auxiliary, local county medical auxiliaries throughout the state, and personal donations. This "interest-free" loan is made available to one student nurse each year who best meets the requirements of application. Terms for repayment are based upon individual circumstances of the approved applicant. Anyone wishing further information concerning the loan fund either for contributions, or for referring someone for application for a loan should contact Mrs. James M. Cooper, chairman, MSMAA Nurse's Loan Fund, 1007 Taft Street, Tupelo 38801.



Mrs. Doyle P. Smith of Jackson (at left), auxiliary treasurer, presents the check to Ms. Marie Crispin, loan recipient, assisted by Mrs. James M. Cooper of Tupelo, Nurse's Loan Fund Chairman.

Family Practice Review Course Draws Physicians



A weeklong family practice review at Jackson helped prepare physicians for board examinations. The University of Mississippi Medical Center family medicine department and the continuing education division cosponsored the course. Dr. Enrique Flechas of Natchez, left, Dr. W. Paul Wilcox of Meridian, center, and Dr. John G. Atwood of Meridian were among state physicians who participated in the course.

MSMA Protests Planning Guidelines

MSMA has strongly protested recent health planning guidelines for hospital services issued by the Department of HEW citing their adverse impact on Mississippi's hospitals.

In a strongly worded letter to the state's Congressional delegation, MSMA pointed out that the effect of the guidelines would be to close most of the state's hospitals.

Subsequent to the MSMA action the U. S. House of Representatives by a vote of 357-0 formally urged HEW Secretary Joseph A. Califano to exempt many rural and community hospitals from the guidelines.

The health planning guidelines were issued by HEW under authority of Public Law 93-641. The National Health Planning and Resources Development Act of 1974, proposed a 4.0 hospital bed capacity per 1,000 population, and an 80 per cent hospital occupancy rate among other guidelines for planning hospital services. The guidelines would be implemented by Health Systems Agencies in each state. An official of Hew stated that the guidelines had generated "an exceptional response" from throughout the nation.



Vertigo spoils the view.

■ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

■ **Dosage for Vertigo*** —The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

* INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children. Clinical studies establishing safety and effectiveness in children have not been done, therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy. See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer

A Division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*



THE STRENGTH TO OVERCOME EXCESSIVE ANXIETY IN THE ELDERLY CARDIAC PATIENT.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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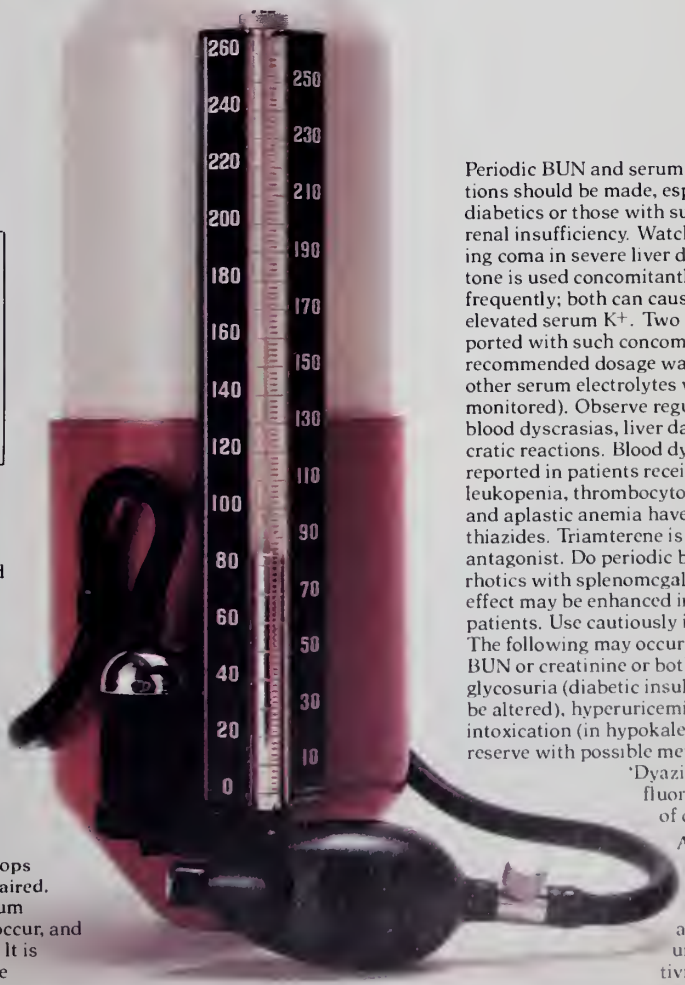
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Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION:* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

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aspirin, 227 mg; phenacetin, 162 mg;
and caffeine, 32 mg.

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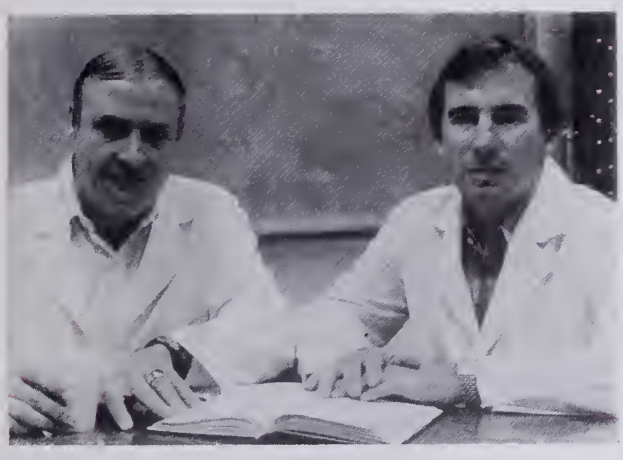
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codeine phosphate, 30 mg (gr ½),
(Warning: May be habit-forming);
and acetaminophen 300 mg.

C III

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Physicians Take EKG Intensive Course



Dr. David B. Dale of Jackson (left) and Dr. R. Michael Foose of Yazoo City participated in the University of Mississippi Medical Center EKG intensive course for physicians Oct. 10-14. The Department of Medicine cardiology division and University Medical Center continuing education division cosponsored the weeklong course.

Medical Center Adds to Faculty

Two assistant professors and two instructors have been named to the faculty at the University of Mississippi Medical Center.

UMC Vice Chancellor and School of Medicine dean Dr. Norman C. Nelson announced the appointments following approval of the Board of Trustees, Institutions of Higher Learning.

Joining the School of Medicine staff are Dr. John Vernon Richey, assistant professor of anesthesiology and co-medical director of the adult intensive care unit, and Dr. Sydney Gordon Grant, assistant professor of family medicine.

New centerwide faculty are Dr. John M. Barnett, instructor in microbiology, and Dr. Gregory Martin Hockel, physiology and biophysics instructor.

Dr. Richey earned the B.S. degrees at Louisiana State University. He did his internship at the University of Texas Medical Branch in Galveston. An Army veteran, he comes to UMC from the Baylor College of Medicine in Houston where he had been on the anesthesiology faculty since 1975.

Dr. Grant received his B.A. degree from the University of New Brunswick, Fredericton, New Brunswick, Canada, and his M.D. degree from Dalhousie University School of Medicine, Halifax, Nova Scotia, Canada. He did his internship at Dalhousie and has been in private practice in Canada since 1967.

Dr. Barnett received his B.S. degree from Delta State University in Cleveland and his Ph.D. from Mississippi State University. He took postdoctoral fellowships at Scripps Clinic and Research Foundation, La Jolla, CA and the Mississippi Medical Center.

Dr. Hockel earned the B.A. at California State University, Long Beach. He received his Ph.D. from Indiana Medical Center, Indianapolis, in June 1977.

State Medical Assistant Receives National Award

Carol Lockey of Pearl was recognized by Central Medical Society at its November meeting for her work as Editor of the American Association of Medical Assistants-Mississippi Society's publication the *Review*.

The *Review* won a First Place Award in publications at the recent 21st Annual Convention of the AAMA in San Francisco. Some 24 Mississippi medical assistants were present at the award ceremony.

The American Association of Medical Assistants was founded in 1956 and has as its prime goal the education of medical assistants. AAMA has 18,000 members nationwide, with 525 local chapters in 46 states. Physicians serve as advisors to the AAMA's local, state and national chapters.

In 1963 AAMA pioneered in offering the only certification program in this field. The program is designed to evaluate professional competency. Medi-



AAMA-Mississippi Society won a First Place Award in Publications at the AAMA 1977 National Convention. Showing the plaque are from left, Wini Schwartz, CMA-AC, AAMA Vice-president and National Awards Chairman, Los Angeles; Carol Lockey, AAMA-MS Publications Chairman and editor of the Mississippi newsletter, the REVIEW; and Joan C. Michaels, CMA-A, AAMA President, Charlotte, NC. Ms. Lockey also serves as AAMA-Mississippi Society Executive Board Member and as president of Central Chapter.

cal assistants and medical assisting instructors and students who successfully complete the examination are entitled to use the initials CMA—Certified Medical Assistant—after their names. In addition to general certification, candidates may also earn certification in administrative (CMA-A) and clinical (CMA-C) specialties.

In collaboration with the American Medical Association's Committee on Allied Health, Education and Accrediation, the AAMA Curriculum Review Board is recognized by the United States Commissioner of Education as an official accrediting agency for medical assisting programs. There are now 122 accredited post-secondary programs in medical assisting in 113 institutions in 28 states. Mississippi now has one institution which is accredited for such post-secondary programs.

New Orleans Will Host Southeastern Surgical Congress

New developments in major areas of surgery will be spotlighted at the 46th annual assembly of the Southeastern Surgical Congress, Feb. 19-23 at the Fairmont Hotel in New Orleans.

Some 2,000 surgeons, surgical nurses and medical and nursing students are expected to attend, according to Dr. Thad M. Moseley of Jacksonville, president; and Dr. A. Hamblin Letton of Atlanta, director.

The 13 southeastern states, District of Columbia and Puerto Rico will be represented. Dr. Watts R. Webb, chief of surgery, Tulane Medical School, is local arrangements chairman.

Nationally-known surgeons invited as guest speakers are: Dr. Oliver H. Beahrs, head of surgery, Mayo Medical School and Clinic; Dr. Hiram C. Polk Jr., chairman, department of surgery, University of Louisville School of Medicine; Dr. Erle E. Peacock Jr., professor, department of surgery, Tulane University School of Medicine; Dr. Robert E. Hermann, staff surgeon, the Cleveland (Ohio) Clinic; and Col. (Dr.) Basil A. Pruitt Jr., director, Army Institute of Surgical Research, Brooke Army Medical Center, Ft. Sam Houston, TX. Dr. R. J. Field of Centreville will speak on total intra-abdominal colectomy for massively bleeding diverticulosis on Wednesday.

Dr. Alexander Heard, chancellor of Vanderbilt University, will address the opening session Monday morning.

The registered nurses' educational program running concurrently will present nationally-known surgeons and highly-specialized nurses discussing new operating room nursing procedures ranging from neurosurgery to newborn emergencies. Alvera de Lima, R.N., of Ochsner Medical Foundation and Clinic, New Orleans, is program coordinator.

A postgraduate course for surgeons on "Infections" will be chaired by Dr. William R. Sandusky of the University of Virginia Medical School. Scientific and postgraduate sessions for physicians and nurses' sessions are accredited for continuing education.

More information is available from SSC headquarters; 315 Boulevard Dr. NE, Atlanta 30312.

LETTERS

SIRS: Friends of an institution who have given its programs longtime and continuing support are sometimes taken for granted. I do not want to fall into that error, so let me say at the outset how much the School of Medicine, and indeed, the Medical Center, values your friendship, your keen interest in medical education and your counsel. In academic medicine, there is always a danger of getting too far away from community practice and health needs at the local level. You help us stay in touch with and responsive to what Mississippians want and need, and for this we are especially grateful.

The people of this state, through their elected officials, continue to be generous with this Medical Center and the School of Medicine in allocation of appropriated monies. But unfortunately, the ever escalating costs of routine operation leave little extra in the budget to develop new programs or add innovative dimensions to existing ones. Thus we have come to depend on unrestricted gifts, particularly those from the American Medical Association Education and Research Foundation, for the leeway we must have to meet an urgent, unbudgeted need—or attempt a new idea which might benefit our state.

Since 1962, this School of Medicine has received AMA-ERF gifts totalling $216,307.46. I know that is a figure in which you take pride and one, I assure you, which has had enormous impact on medical education in Mississippi. I hope you will choose to participate in the AMA-ERF this year and again join with us in our continuing pursuit of excellence in medical education as we train physicians for this state.

NORMAN C. NELSON, M.D.
Vice Chancellor for Health Affairs
Dean, School of Medicine
University of Mississippi

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Canton Exchange Bank 14
Coca-Cola 7
Harreld Chevrolet-Oldsmobile 19
Hill Crest Hospital 8
Eli Lilly and Company 18A
Mead Johnson Laboratories 8A, 8B, 8C, 8D
Merck Sharp and Dohme 15, 16
Mississippi Stationery Company 10
New Orleans Graduate Medical Assembly 4
Pennwalt Corp. 18B, 18C
Premier Printing Company 11
Riverside Hospital 12
Roche Laboratories . . . . . second cover, 3, 20B, third and fourth covers
Roerig and Company 6, 6A, 20A
Smith Kline and French 20C
E. R. Squibb and Sons 10A, 10B
Thomas Yates and Company 18

IN CONCLUSION

A special study of the costs of various major national health insurance programs released by HEW reveals that the Health Security Act sponsored by Senator Edward M. Kennedy and supported by the AFL-CIO would add some $130 billion to the nation's health bill. Using 1980 as the base year for comparing operational costs for several proposals now before Congress, independent actuaries found the HSA the most expensive proposal. Long-Ribicoff bill would add $15.6 billion and AMA and AHA plans $22.7 billion and $36.5 billion respectively.

Obesity is a serious medical, psychological, social problem shared by over 70 million Americans who spend over $10 billion annually for antiobesity prescriptions, over-the-counter suppressants, reducing pills and diuretics, diet books, mechanical devices, health spas, fat farms and other allied items, according to a new study by Frost and Sullivan, a New York-based market research firm. It is also estimated that three out of every 10 adults between 40 and 60 years of age are overweight, with an estimated 50,000 yearly dying from obesity as a secondary cause.

The American Medical Association has called for physicians in private practice to take an active role in the current national effort to vaccinate children against infectious disease. Of the 52 million children younger than 15 years in the U. S., approximately 20 million have not been immunized adequately against the seven most common childhood diseases: polio, measles, rubella, pertussis, tetanus, diphtheria and mumps. Two thirds of these are in families that use private health care providers, rather than public agencies.

Although hospital costs are not increasing as rapidly as in the past, many hospitals are nonetheless experiencing serious financial problems and more are likely to confront such problems in the future, according to an analysis by Touche Ross in Health Care Horizons. In 1976, according to the survey, there was no significant increase in the overall adult hospital occupancy rate or in the length of patient stay. Operating expenses per weighted patient day increased from $160.08 in 1975 to $178.22 in 1976, excluding interest and depreciation.

The White House and HEW apparently are not synchronized on an introduction date for National Health Insurance. HEW Secretary Califano, after a European trip to look at NHI in action and recent public hearings around the country, sees early 1979 as a feasible date. The White House says early next year. As to what funding mechanism NHI will use, Washington observers are now saying that with recent large increase in Social Security taxes a federally financed program is definitely out. Tax credits and vouchers to purchase medical coverage as proposed in AMA bill seems more practical.

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5mg, 10mg, 25mg capsules

Libritabs® (chlordiazepoxide) available in 5 mg, 10 mg and 25 mg tablets.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE Roche Products Inc.
Manati, Puerto Rico

Please see following page.

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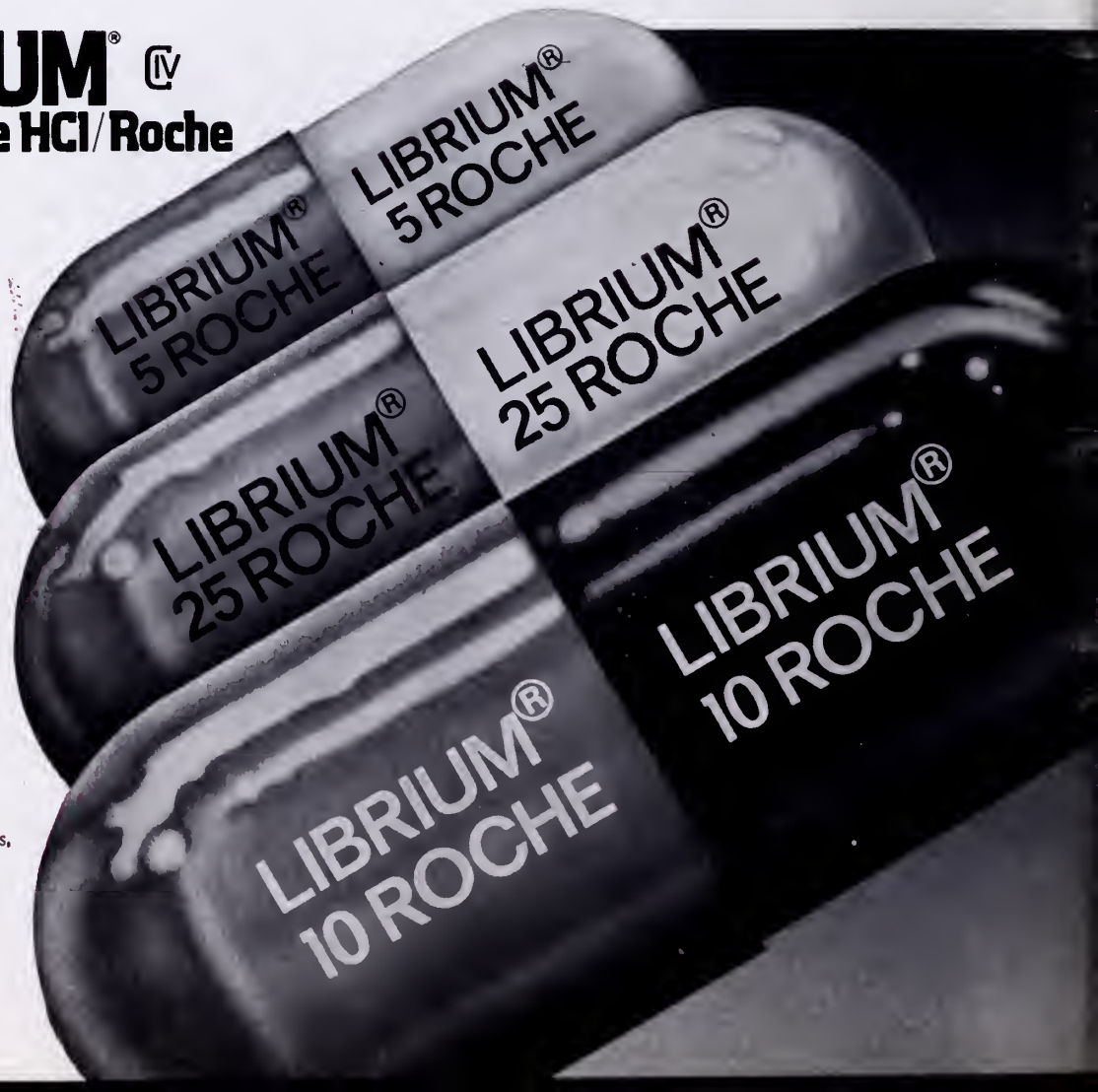
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*If you have a question about Librium or any other Roche product, write to Professional Services, Roche Laboratories, Nutley, New Jersey 07110.

Please see preceding page for a summary of product information.

February 1978

BALCONY

Journal of the State Medical Association

Mississippi



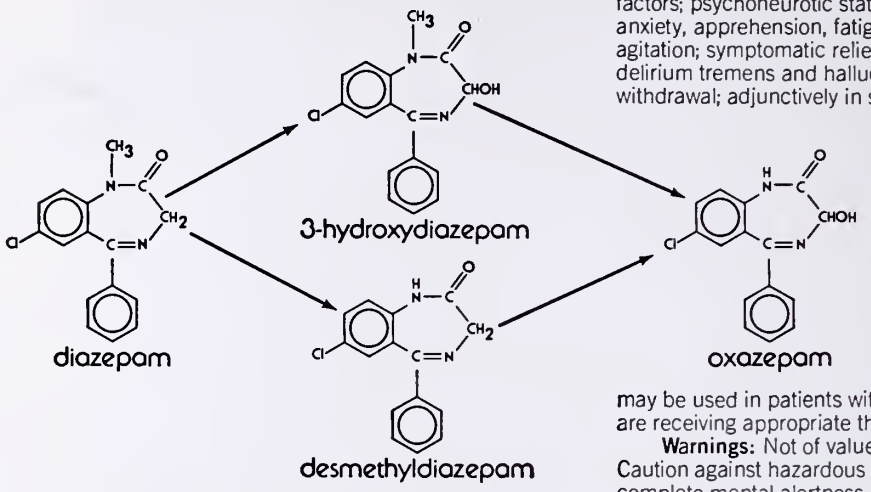
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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The clinical program incorporates a wide range of modern psychiatric ideas. Emphasis is placed on interpersonal relationships, small group functions, and professional individualized care.

The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

For additional information contact: John R. Reedy, Executive Director.



Riverside Hospital

P.O. Box 4297, Jackson, MS 39216
Telephone: (601) 939-9030

Volume XIX
Number 2
February 1978



JOURNAL of the Mississippi
STATE MEDICAL ASSOCIATION

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CONTENTS

ORIGINAL SCIENTIFIC PAPERS

The Battered-Child Syndrome and Its Management **23** B. Frank Vogel, M.D., Hattiesburg, MS

The Acute Afferent Loop Syndrome **26** William O. Barnett, M.D., Jimmy L. Hamilton, M.D., and Hugh A. Gamble, M.D., Jackson, MS

SPECIAL ARTICLE

Radiologic Seminar CLXXVIII: The Air-Fluid Level in the Retrocardiac Space **28** Walter T. Colbert, M.D., Natchez, MS

EDITORIAL

The Escalating Cost of Medical Care; Everyone Has a Solution: No One Has the Answer **31** W. Moncure Dabney, M.D., Crystal Springs, MS

THIS MONTH

The President Speaking **30** Congress and Medicine: 1977 Was a Good Year

Medical Organization **39** The 110th Annual Session of MSMA Is Scheduled for May 1-4 at Jackson

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If in Jackson: 969-6811

Kidney Diseases Will Be Studied in Atlanta

A comprehensive program on "Kidney Diseases—Present Status" will be presented at the annual meeting of the U. S.-Canadian Division of the International Academy of Pathology in Atlanta. The course will be given Wednesday, Mar. 8 at the Atlanta Hilton Hotel.

Course directors are Dr. Jacob Churg, Mount Sinai School of Medicine, New York, NY; Dr. Benjamin H. Spargo, Department of Pathology, University of Chicago, Pritzker School of Medicine; and Dr. F. K. Mostofi, Genitourinary Pathology Branch, Armed Forces Institute of Pathology, Washington, DC.

Further information may be obtained from Dr. Leland D. Stoddard, Secretary-Treasurer, U. S.-Canadian Division, International Academy of Pathology, Department of Pathology, Medical College of Georgia, Augusta, GA 30902. Telephone (404) 724-2973.

UMC Plans Gastroenterology Update

An 11-member faculty will lecture to physicians from throughout the Southeast during the University of Mississippi Medical Center "Gastroenterology Update" Mar. 30, 31 and Apr. 1.

Conference headquarters is the Ramada Inn Coliseum in Jackson.

Dr. James L. Achord, UMC professor of medicine and director of the digestive diseases division, is course coordinator. Dr. William O. Barnett, clinical professor of surgery; Dr. John Y. Gibson, assistant professor of radiology and director of ultrasound; and Dr. Rebecca Harrell, assistant professor of radiology, and digestive diseases fellow Dr. Thomas V. Allen join a guest faculty of six gastroenterologists for discussions of esophagitis, peptic ulcer disease, gallstones, inflammatory bowel disease, and hepatitis.

The UMC School of Medicine Department of Medicine Division of Digestive Diseases and the University Medical Center Division of Continuing Health Professional Education are sponsors.

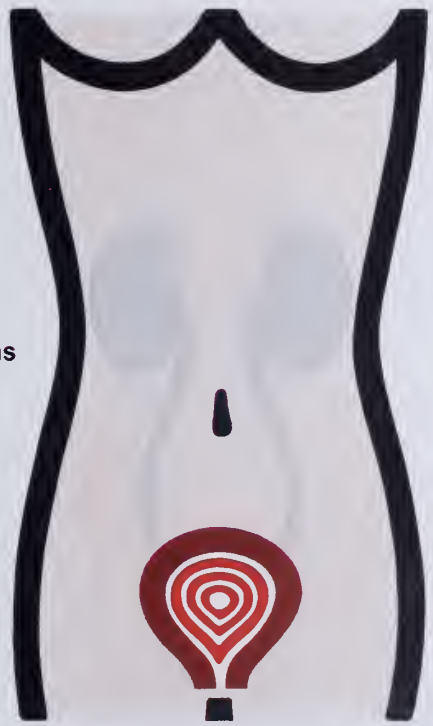
Registration fee is $150 for any or all portions of the program. The course meets the requirements for 18 credit hours in Category I of the Physician's Recognition Award of the American Medical Association, and the American Academy of Family Physicians has approved the course for 18 credit hours.

When pain complicates acute cystitis*

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl

for the pain for the pathogens



□ **Early relief of painful symptoms** such as burning and pain associated with urgency and frequency.

□ **Effective control of susceptible pathogens** such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris.*

□ **Appropriate antibacterial therapy:** up to three days therapy with Azo Gantanol, then 11 days with Gantanol® (sulfamethoxazole), 0.5 Gm tablets.

*Nonobstructed; due to susceptible organisms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

***Note:* Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult* dosage: 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

Note: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

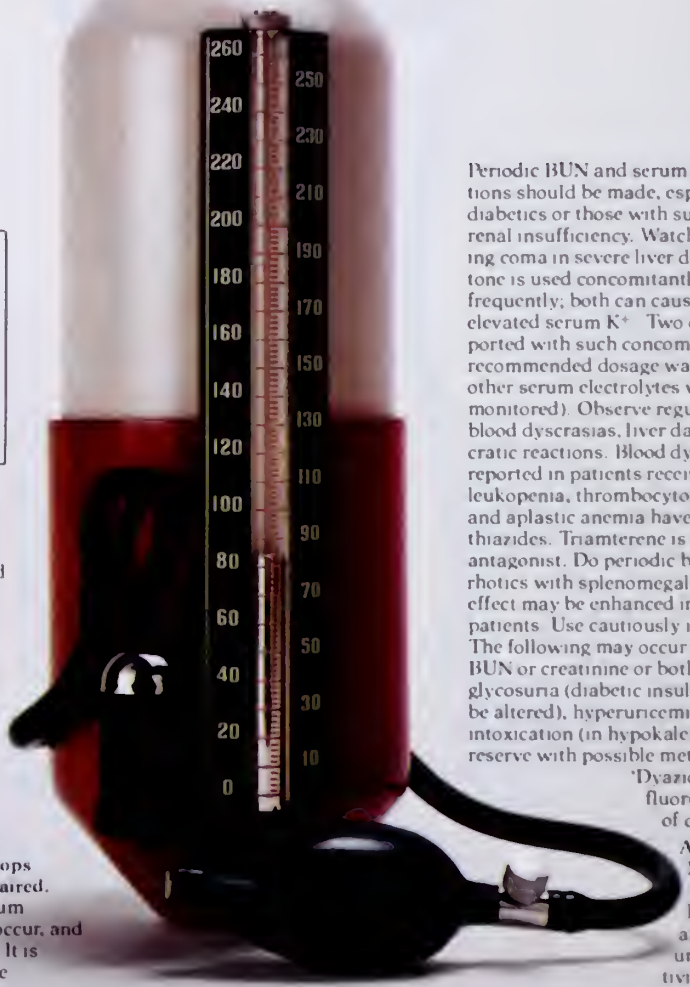
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MAKES SENSE



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* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome, Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

'Dyazide' interferes with fluorescent measurement of quinidine

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions, nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

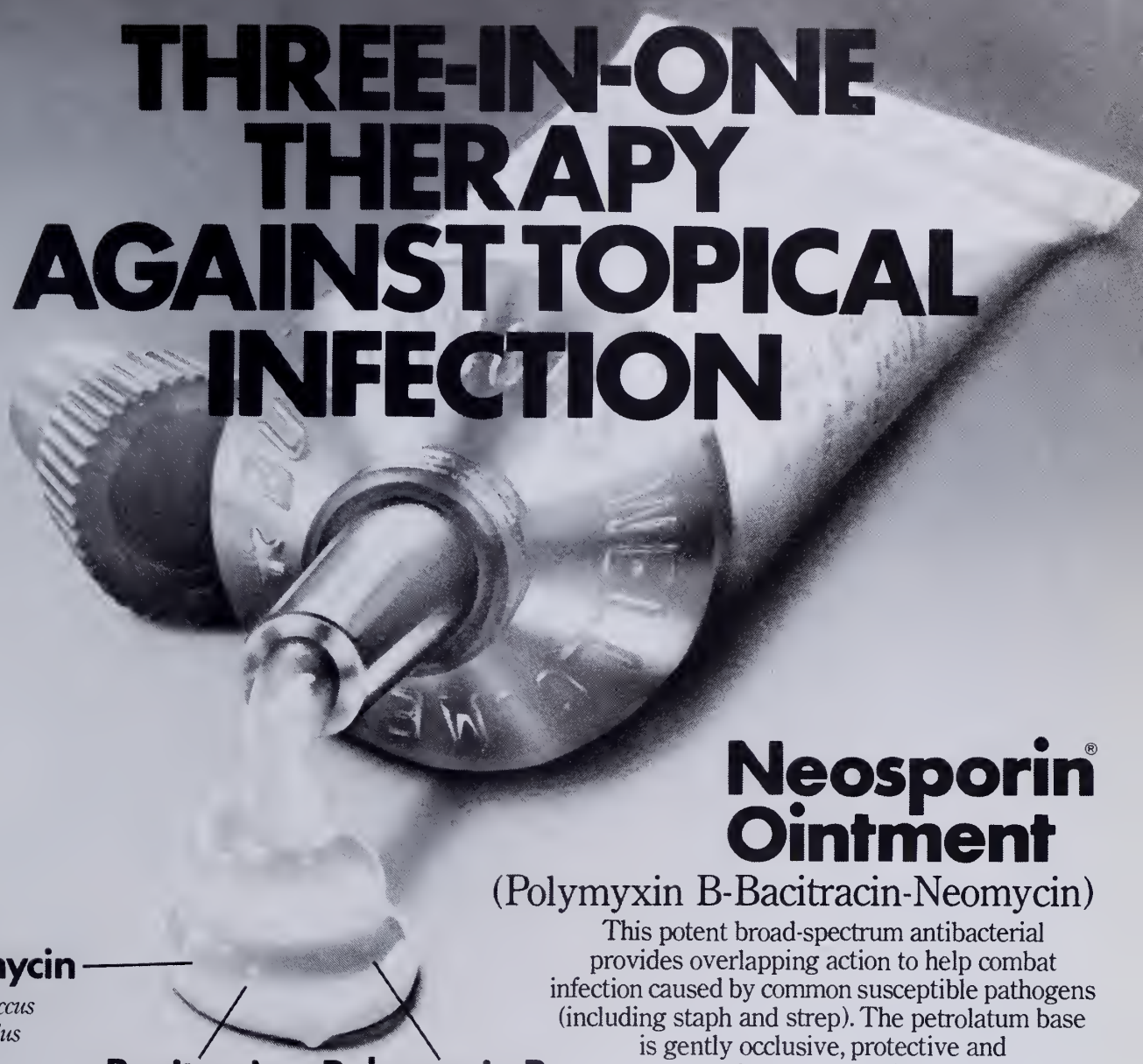
Supplied: Bottles of 100 and 1000 capsules. Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

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Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

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Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

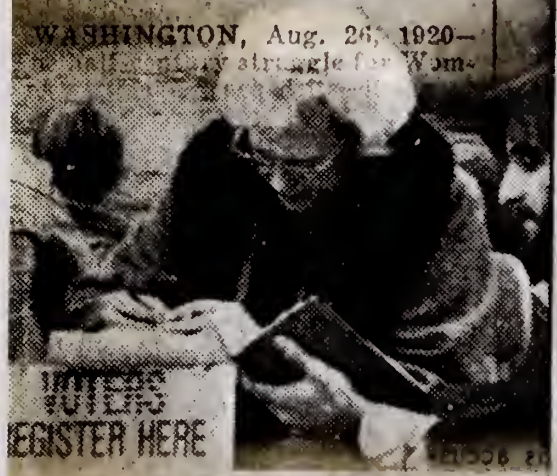
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MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Jobles

Roosevelt Approves Message Intended to Benefit 30,000,0 Persons When States Adopt Cooperating Laws–He Call the Measure 'Cornerstone' of His Economic Program.

WASHINGTON, Aug. 14, 19
The Social Security Bill, provid
a broad program of unemploym
insurance and old age pensi
and counted upon to benefit s
20,000,000 persons, became law
day when it was signed by Pr
dent Roosevelt in the presence
those chiefly responsible for
ting it through Co
Mr. Roosevelt cal
"the cornerstone
which is being
mea

COMPL

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent

TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session the President accompanied the

SIGNE

the Draft Ends Nov

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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NEWSLETTER

February 1978

Dear Doctor:

By a vote of 178-46 the AMA House of Delegates reaffirmed support for the AMA's Comprehensive Health Insurance Program, the proposal now in Congress as HR 1818 and S 218. In its recommendation the reference committee felt "compelled to observe that the issue of support of a program of comprehensive health insurance has been one of the most divisive issues for the profession in recent years...It has been a time-consuming but necessary debate."

More than $5.3 million in guaranteed loans for medical students and $1.18 million in grants to medical schools were made possible by the AMA Education and Research Foundation during the first nine months of last year. During that period approximately 3,800 students and physicians-in-training benefitted from AMA-ERF fund.

From July 1, 1976, through June 30, 1977, the UMC newborn transport team took 240 sick infants to the Medical Center or to one of the regional newborn centers throughout the state for specialized care. The survival rate of 76 per cent for the Mississippi team matched that reported by the New York University Medical Center's transport team in a similar study.

A continuing decline in the national infant mortality rate has been reported by the National Center for Health Statistics. The rate was 14.5 per 1,000 live births in the 12 months ending with July 1977. This new rate reflected an improvement from the 15.5 per 1,000 live births for the same period a year earlier ending July 1976.

Total enrollment in the 116 U.S. medical schools in 1976-77 was 58,266, an increase of 2,022 over the previous year, reports the AMA's 77th annual report on medical education. First-year enrollment increased from 15,351 in 1975-76 to 15,667 in 1976-77. In Mississippi there were 152 students entering the UMC in 1977 and total enrollment was 599 compared to 565 in 1975-76.

Latest HEW quality control report indicates MS. Dept. of Public Welfare has one of highest payment error rates in administering Aid to Families with Dependent Children (AFDC) program of any state in South. During Jan.-June 1977, 7.4 per cent MS. AFDC cases were either ineligible or overpaid compared to 5.2 percent in base period Apr.-Sept. 1973. AFDC recipients are also eligible for Medicaid.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

Surgical Forum Is Set for March

Surgeons from across the nation will meet in Jackson Mar. 9-11 for the fifth annual University of Mississippi School of Medicine Surgical Forum.

The two and one-half day seminar for general surgeons will include lectures and panel discussions by an international guest faculty.

The course is sponsored by the UMC Department of Surgery and the Medical Center Division of Continuing Health Professional Education. Coordinators are Dr. James D. Hardy, UMC professor of surgery and department chairman, and Dr. William O. Barnett, UMC clinical professor of surgery.

University of Mississippi School of Medicine faculty on the program are Dr. James L. Achord, professor of medicine and director of the division of digestive diseases; Dr. Walter T. Boone, clinical assistant professor of medicine; Dr. Robert S. Caldwell, clinical assistant professor of surgery; and Dr. J. Harvey Johnston, Jr., clinical professor of surgery.

Other UMC faculty lecturers are Dr. Richard C. Miller, University Hospital medical director, School of Medicine associate dean, professor of surgery and assistant professor of pediatrics; Dr. Patricia Moynihan, associate professor of surgery and assistant professor of pediatrics; and Dr. Norman C. Nelson, UMC vice chancellor for health affairs, medical school dean and professor of surgery.

Pulmonary problems in the general surgical patient, surgical management of obesity, management of hyperthyroidism, splenectomy and bile duct injuries are among topics to be discussed.

General sessions will be at the Holiday Inn Downtown. Attendance is by invitation and advance registration is required. Applications will be accepted in the order received. Those who cannot be accepted will be notified at the earliest possible time.

Registration fee is $150 for any and all portions of the program. The course meets requirements for 17 credit hours in Category 1 for the Physician's Recognition Award of the American Medical Association.

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738-[illegible]

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* **INDICATIONS:** Based on a review of this preparation by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: **Possibly effective:** In cutaneous candidiasis; superficial bacterial infections; the following conditions when complicated by candidal and/or bacterial infection: atopic, eczematoid, stasis, nummular, contact, or seborrheic dermatitis, neurodermatitis, and dermatitis venenata; infantile eczema; lichen simplex chronicus; and pruritus ani and pruritus vulvae.

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Viral diseases of the skin (such as vaccinia and varicella); fungal lesions of the skin except candidiasis; history of hypersensitivity to any product component. Not intended for ophthalmic use; should not be applied in the external auditory canal of patients with perforated eardrums; should not be used when circulation is markedly impaired.

WARNINGS: Because of the potential hazard of nephrotoxicity and ototoxicity, prolonged use or use of large amounts of this product should be avoided in the treatment of skin infections following extensive burns, trophic ulceration, and other conditions where absorption of neomycin is possible.

Usage in Pregnancy: Although topical steroids have not been reported to have an adverse effect on the fetus, the safety of topical steroids during pregnancy has not been absolutely established; therefore, do not use extensively on pregnant patients, in large amounts, or for prolonged periods.

PRECAUTIONS: Watch constantly for overgrowth of nonsusceptible organisms (including fungi other than candida). Should superinfection due to nonsusceptible organisms occur, administer suitable concomitant antimicrobial therapy; if favorable response is not prompt, discontinue the preparation until adequate control by other anti-infectives is effected. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid; suitable precautions should be taken. If irritation develops, discontinue the product and institute appropriate therapy.

ADVERSE REACTIONS: Sensitivity reactions to topical use of gramicidin are rare. Hypersensitivity to nystatin is extremely uncommon. Hypersensitivity to neomycin has been reported and articles in the current medical literature indicate an increase in its prevalence.

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For full prescribing information, consult package insert.

HOW SUPPLIED: Available in 15, 30, and 60 g. tubes. It is also available in jars of 120 g. (4 oz.) for hospital or institutional use only.

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U. S.-Canadian Academy Of Pathology Meets

The sixty-seventh annual meeting of the U. S.-Canadian Division of the International Academy of Pathology will be held at the Atlanta Hilton Hotel in Atlanta, GA, Mar. 6-Mar. 10. The annual Maude Abbott lecture will be delivered by Dr. E. A. Saxen, Department of Pathology, University of Helsinki, Helsinki, Finland.

Scientific papers, poster sessions, 11 pathology specialty conferences, 46 short courses, a special course on Electron Microscopy in Diagnostic Pathology, and the Long Course on "Kidney Diseases —Present Status," directed by Drs. Jacob Churg, Benjamin H. Spargo, and F. K. Mostofi, will be given during the meeting.

Further information about the meeting and courses may be obtained from Dr. Leland D. Stoddard, Secretary-Treasurer, U. S.-Canadian Division, International Academy of Pathology, Department of Pathology, Medical College of Georgia, Augusta, GA 30902. Telephone (404) 724-2973.

Dr. George Mann Is Visiting Professor

Dr. George V. Mann of Nashville, nationally-known for his research on nutrition, was at the University of Mississippi Medical Center Jan. 15-18 as visiting professor in the Department of Preventive Medicine.

His is one of two School of Medicine visiting professorships made possible this year through gifts from the Medical Alumni Chapter of the University of Mississippi Alumni Association.

Dr. Mann is professor of medicine and biochemistry at Vanderbilt University School of Medicine.

Recognized for his field studies among the Eskimos in Alaska and the Pygmy and Masai tribes in Africa, Dr. Mann is a Cornell University graduate and earned the M.D. degree at Johns Hopkins School of Medicine. His major research interests are atherogenesis, human nutrition and cardiovascular epidemiology.

Dr. Mann is career investigator of the National Health and Lung Institute and an established investigator of the American Heart Association. He is on the editorial board of *Physician and Sports Medicine* magazine and has published over 150 scientific articles and a book, *Food and Health*.

MARCH 31-APRIL 4, 1978

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DATELINE

Some Professions Can Advertise

Columbus, OH - The Ohio Supreme Court ruled that individual lawyers can advertise legal services in print and on radio and television, if it is done in a dignified manner. Decision bars the use of drawings, illustrations, animation, portrayal, dramatization, slogans, music, lyrics, or pictures, except for pictures of the advertiser. Advertising by dentists won approval of the Virginia attorney general who said he was following the Supreme Court's June opinion on lawyers' advertising.

Mass. Med Students Must Pay Back State

Worcester, MA - Students entering the University of Massachusetts medical school in Worcester must pay the state $8,000 after graduation or work one year in the Commonwealth to pay back the real cost of their education, the university's board of trustees voted. The vote brings the university into compliance with a new state law requiring medical students to repay the state in money or in services. Students' tuition is $900 per year.

AMA Offers Health Education Materials

Washington, DC - All members of the U.S. Congress have been offered American Medical Association assistance in responding to inquiries from constituents on health or medical problems. In a letter to each senator and representative, the AMA Washington office enclosed three AMA health education phamplets that "are quickly and readily available in bulk of needed." A "medical backgrounder," covering AMA policies and positions on health subjects was also sent each lawmaker.

Foreign Medical Graduates and Exams

Washington, DC - Only 25 per cent of foreign medical graduates who took the new Visa Qualifying Examination last fall passed the test, according to the National Board of Medical Examiners. Under the new Health Manpower Act, foreign medical graduates must pass the VQE and an English language proficiency test before receiving either an exchange visitor or immigrant visa. Results showed that foreign physicians tended to perform better on the clinical than on the basic science test.

HEW Issues New Planning Guides

HEW's National Guidelines on Health Planning drew over 50,000 comments, most in opposition, and resolutions from Congress urging that the Guidelines be made more flexible. Probably in recognition of this, HEW issued a revision of the Guidelines on January 20, allowing a comment deadline of February 21, 1978. New Guidelines set goals of annual hospital occupancy rate of 80 per cent and 4.0 hospital beds per 1,000 population both of which will hit Mississippi hard.

Human Sexuality Course Scheduled

The Institute for Sex Researeh will hold its ninth annual summer program in human sexuality June 21-28, 1978.

Leetures, panel diseussions, audiovisual materials, and attitude reassessment workshops eovering sex behavior, sex therapy, and eurrent sociosexual issues will be offered. Courses are designed for individuals in the health professions and other professional fields and are conduеted by ISR staff and distinguished guest lecturers. Registration fee is $325.

For more information contaet Institute for Sex Researeh—Summer Program, 416 Morrison Hall, Indiana University, Bloomington, IN 47401.

A Look at Canada's Health Plan

Would national health insuranee solve the dilemma of rising medical eare eost?

A laboratory for study, says the Health Insuranee Institute, is in our neighbor to the north—Canada—whose eitizens are enrolled in a compulsory health insuranee program.

The Canadian government and the provinces share the eosts of health eare on a nearly equal basis. However, the provinces administer the health plans.

Sinee 1972, aecording to various studies, overall federal eontributions to the provinces have risen about 15 per cent annually. In 1975, after the federal government had pledged to hold overall spending increases to 10 per cent, the federal share of health cost rose nearly 20 per eent.

In all 10 provinces, eitizens pay for health eare eosts through general taxes. But in 4 of the 10 provinees, citizens not only pay taxes but also are charged annual premiums.

Ontario is one of these four. The most populous provinee, representing more than 36 per eent of Canada's population, it has the largest health plan.

The largest single item in Ontario's budget is health eare. It now aeeounts for 33 per eent of provincial expenditures. Sinee 1972, Ontario's spending on health insuranee has risen 101 per eent, while the total provineial revenue has risen only 79 per eent—and the population 10 per eent.

The number of medieal elaims in Canada has increased 60 per eent in five years, although the insured population has grown only 6 per cent.

Eugene Vayda, M.D., professor at the University of Toronto, reeently had this to say about the costs of Canada's national health insuranee:

"In 1965, the total cost of health eare services was $3.3 billion—in 1970, $6 billion, and in 1975, over $11 billion. The magnitude of these expendi-

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

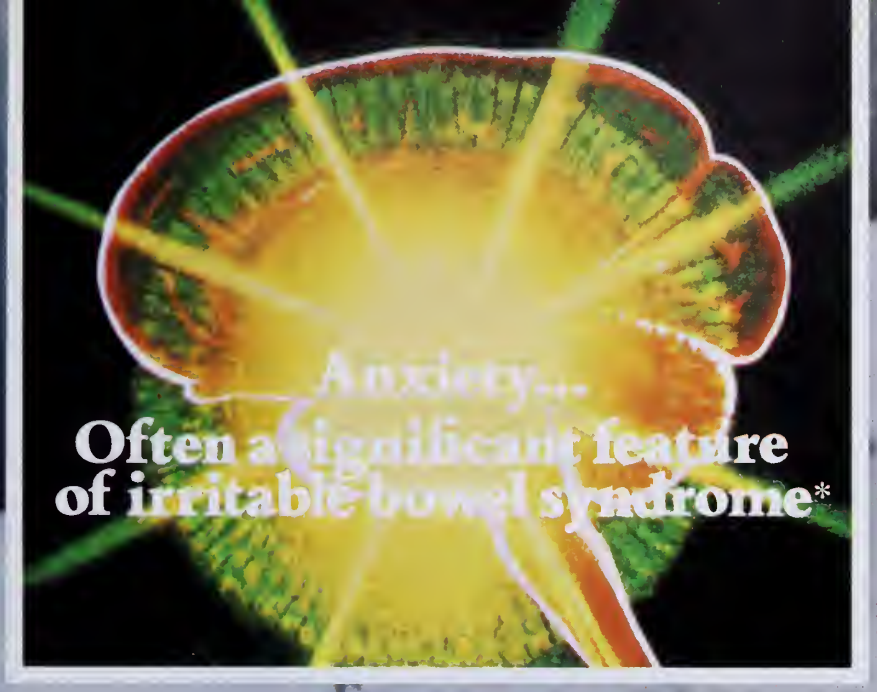
As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema; minor menstrual irregularities; nausea and constipation; extrapyramidal symptoms; increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl; making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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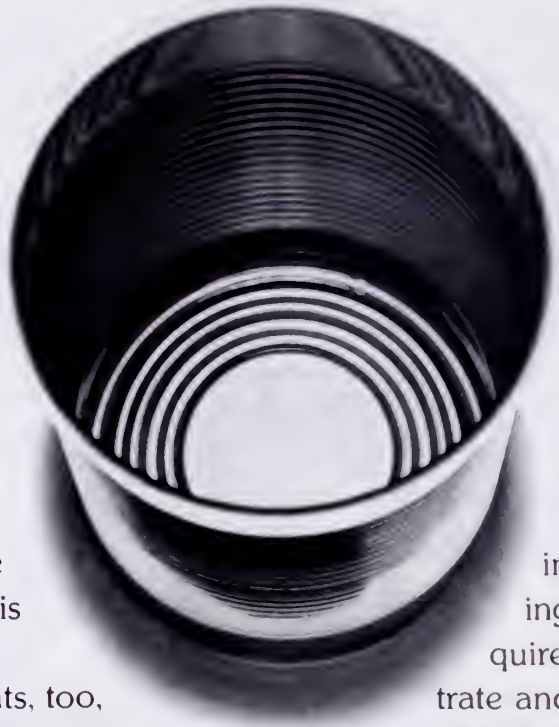
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*Librax has been evaluated as possibly effective for this indication.
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tures and the rate of their increase has captured the attention and concern of the politicians. Health care in Canada has now moved into the political arena, and is there to stay."

Medical Society Names Health Committee

Members of the West Mississippi Medical Society, in the 1978 committee assignments, have formed a new committee with general community health checks as its duty.

Dr. Leo Scanlon, newly chosen president of the physician's organization, named four local medical doctors members to the committee. They were: Larry V. Hoffman, chairman; F. Lamar McMillin; Patrick G. McLain; and Gene W. Warren.

Their function, Dr. Scanlon said, will be to identify "community medical and health needs which organized medicine should be aware of and possibly act upon."

"To act as a liaison between the medical society and the county and state public health departments and the U. S. Department of Health, Education and Welfare."

And "to assist in finding and understanding the possible occupational and endemic diseases and other health hazards in the Vicksburg-Warren County community."

"There's been a lot in the news about physicians needing to get in closer contact with the health needs of their communities," Scanlon said. "We formed this committee in an effort to make sure the West Mississippi Medical Society stays informed and so that local doctors could be more informed about the specific medical needs of the community."

University Medical Center Adds to Faculty

Two new assistant professors and two instructors have been named to the faculty at the University of Mississippi Medical Center.

UMC Vice Chancellor Dr. Norman C. Nelson announced the appointments, two in the School of Medicine and two to the centerwide faculty, following approval of the Board of Trustees, Institutions of Higher Learning.

They are Dr. John Edward Forestner, assistant professor of anesthesiology; Dr. Alan E. Freeland, assistant professor of surgery (orthopedics); Dr. Philip R. Kastner, instructor in physiology and biophysics; and Dr. Karen Johnson Houston, instructor in biochemistry.

An alumnus of Northwestern University where he earned his B.A. and M.D., Dr. Forestner interned at the Mississippi Medical Center and did residencies at UMC and the University of Texas Southwestern Medical Center at Dallas. He is an army veteran and served for a year on the Texas Southwestern faculty.

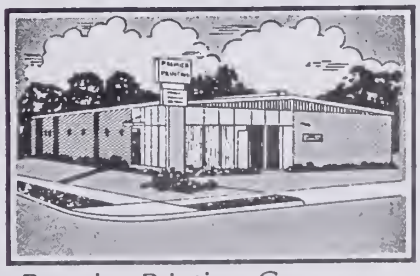
Dr. Freeland holds the B.A. from Johns Hopkins University and earned the M.D. at George Washington. He interned at the Church Home and Hospital in Baltimore, MD, and took residencies at Johns Hopkins, Letterman Army Medical Center in San Francisco and at the Shriners Hospital for Crippled Children in Los Angeles. He comes to the Medical Center following service in the US Army.

Dr. Kastner earned the B.A. at St. Ambrose College, Davenport, Iowa, the M.S. at Western Illinois University, Macomb, IL, and the Ph.D. at the University of Missouri at Columbia. Formerly on the Faculty at Triton Jr. College in River Grove, IL, he comes to the Medical Center from Bowman Gray School of Medicine where he was a postdoctoral fellow.

A graduate of Mississippi University for Women, Dr. Houston earned the M.S. at the University of Mississippi and her Ph.D. at the Medical Center. She has been a public school teacher in Clinton and Jackson and held a postdoctoral fellowship at the Medical Center prior to joining the faculty.

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UMC Family Medicine Clinic Gets New Support Grant

A new five-year grant to the University of Mississippi Medical Center continues support of a Department of Family Medicine model practice clinic which opened its doors to patients three years ago.

First-year funding totals $204,625.

According to family medicine chairman Dr. Wilfred Gillis, the first Department of Health, Education, and Welfare grant for $572,888 expired in June 1977. That initial funding established the Candlestick Family Medical Center in south Jackson.

"Our practice clinic in north Jackson, McWillie, was working well," Dr. Gillis said, "but we needed an additional site to train students and residents as we expanded our program." Currently, there are 27 physicians in the family medicine residency training program.

While state appropriations to the Medical Center pay clerical salaries, utility costs, and a portion of the stipends for residents, most of the expense of Candlestick is borne by federal grant funds. The new DHEW appropriation pays stipends for seven of the nine residents based there, salaries for clinical faculty, and allied health professionals who work in

MISSISSIPPI STATE MEDICAL ASSOCIATION

110th Annual Session

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- Specialty Society Meetings
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- Auxiliary Activities
- House of Delegates
- Tennis Tournament

the clinic. An award from the Mississippi Chemical Corporation also pays a resident's salary.

McWillie is supported entirely by Medical Center state appropriations.

Debrisan Helps Cleanse Wounds

Pharmacia Laboratories of Piscataway, NJ, has begun manufacturing Debrisan® (generic name—Dextranomer). Introduced in November 1977, Debrisan is indicated for use in cleansing secreting wounds such as venous stasis ulcers, decubitus ulcers, infected traumatic and surgical wounds and infected burns. It is supplied in 60-g and 120-g canisters and 4-g unit-dose packages of 7 and 14.

Debrisan consists of small, dry, spherical beads in the range of 0.1-0.3 mm in diameter. The beads are highly porous and extremely hydrophilic. Debrisan actively seeks out and absorbs water and tissue exudates. The Debrisan beads continue to swell in their water-absorbing process until they are completely saturated. When Debrisan is saturated it turns greyish-yellow in color and should be promptly removed from the wound surface before drying and crusting of the beads occurs.

Master's Degree in Nursing Accredied at USM

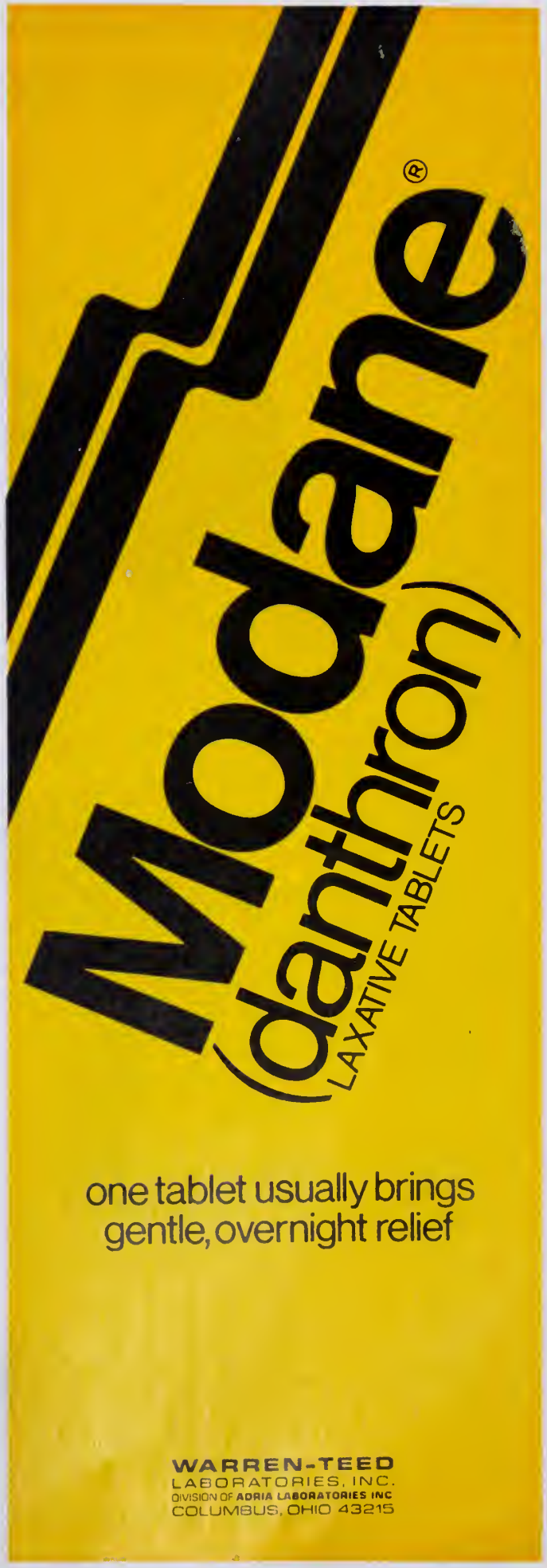
Dr. Elizabeth Harkins, Dean of the School of Nursing at the University of Southern Mississippi, announced this week that the USM master's program in nursing has been accredited by the National League for Nursing.

"This accreditation by the national agency," Dean Harkins said, "is indicative of the quality of education recognized across the nation. Such accreditation is recognized by those in service and in education."

USM first offered the master's program in nursing during the fall quarter of 1974. The school did a self-study in 1976 that brought a national review board to the campus to evaluate the nursing program. The results of this review led to the accreditation which is, according to the dean, "A standard of quality as judged by one's peers."

The accredited status is retroactive for eight months and covers those who received master's degrees in nursing in May graduation exercises. There are 58 students currently enrolled in the nursing master's program at Southern.

The USM School of Nursing also has a baccalaureate program and a continuing education program.



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Actions: Pyrvinium pamoate appears to exert its anthelmintic effect by preventing the parasite from using exogenous carbohydrates. The parasite's endogenous reserves are depleted, and it dies. Povan is not appreciably absorbed from the gastrointestinal tract.

Indication: Povan is indicated for the treatment of enterobiasis.

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Precautions: To forestall undue concern and help avoid accidental staining, patients and parents should be advised of the staining properties of Povan. Care should be exercised not to spill the suspension because it will stain most materials. Tablets should be swallowed whole to avoid staining of teeth. Parents and patients should be informed that pyrvinium pamoate will color the stool a bright red. This is not harmful to the patient. If emesis occurs, the vomitus will probably be colored red and will stain most materials.

Adverse Reactions: Nausea, vomiting, cramping, diarrhea, and hypersensitivity reactions (photosensitization and other allergic reactions) have been reported. The gastrointestinal reactions occur more often in older children and adults who have received large doses. Emesis is more frequently seen with Povan Suspension than with Povan Filmseals.

How Supplied: Each Povan Filmseal® contains pyrvinium pamoate equivalent to 50 mg pyrvinium, supplied in bottles of 50 (NDC 0710-0747-50; NSN 6505-00-134-1966). Povan Suspension, a pleasant-tasting, strawberry-flavored preparation containing pyrvinium pamoate equivalent to 10 mg pyrvinium per milliliter, is supplied in 2-oz bottles (NDC 0071-1254-31; NSN 6505-00-890-1093).

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
February 1978, Vol. XIX, No. 2

ORIGINAL PAPERS

The Battered-Child Syndrome and Its Management

B. FRANK VOGEL, M.D.
Hattiesburg, Mississippi

THE BATTERED-CHILD Syndrome is a shocking sociological phenomenon. It is indeed an emotional problem, not only for those abusing the child, but also for those who encounter the results, such as physicians, nurses, social workers, neighbors, and members of the community. Our emotional reactions are aroused and lead us to do a variety of things from denial of the incident as such, to angry demands for immediate prosecution and removal of the child from the family unit. This is not a new phenomenon, and has been in existence since those early days when the family unit came into being. The helpless, unprotected child has always been a readily available scapegoat. Nevertheless, in uninhibited primitive cultures, child abuse takes place and took place less frequently than it does in our current civilization, where there are many taboos on the free expression of feeling.

For many years, it was known that children were physically abused, and sometimes suffered permanent injury or death. But for a long time, physicians and nursing personnel were reluctant to believe that parents were guilty of physically abusing their children. Even with the advent of x-rays and the finding of multiple fractures in the long bones of infants and children, there was still such a psychological blocking that many learned papers were written suggesting that the findings were variants of scurvy, of syphilis, of osteogenesis imperfecta, or infantile cortical hyperostosis or of osteogenic sarcoma. Finally, this uneasy period, of half-knowing and half-not-wanting to know the real origin of these bizarre x-ray findings, came to an end with the publishing of the classic paper and the first use of the term the Battered-Child Syndrome by Kempe, Silverman, Steele, Droegemuller, and Silver in 1962.[1]

Medical Director, Pine Belt Regional Mental Health and Retardation Complex, Hattiesburg, MS.

Child abuse has become a critical social issue today and produces long-lasting physical and emotional harm to the child, as well as deepening the abusive parent's problems. All physicians are urged to remain alert to the many children at risk. Emotional characteristics of the parents are given as well as the child's reactions. Management of the family interaction is discussed and suggestions are given for interrupting the abusive cycle and reintegrating the family as a viable unit.

Kempe, as a pediatrician, had long been concerned about the many infants and young children he had seen who exhibited bone fractures, subdural hematomas, failure to thrive, soft tissue swellings, bruising and sudden deaths. There were other incidents where the type of injury was markedly at variance with the history given regarding the occurrence of the trauma. Finally, by perseverance and skillful questioning, he succeeded in learning that in every case there had indeed been physical abuse of the child. It has been estimated that at least 700 children in the United States are killed each year and thousands more permanently injured, both physically

and mentally, by their parents or parent substitutes.[2]

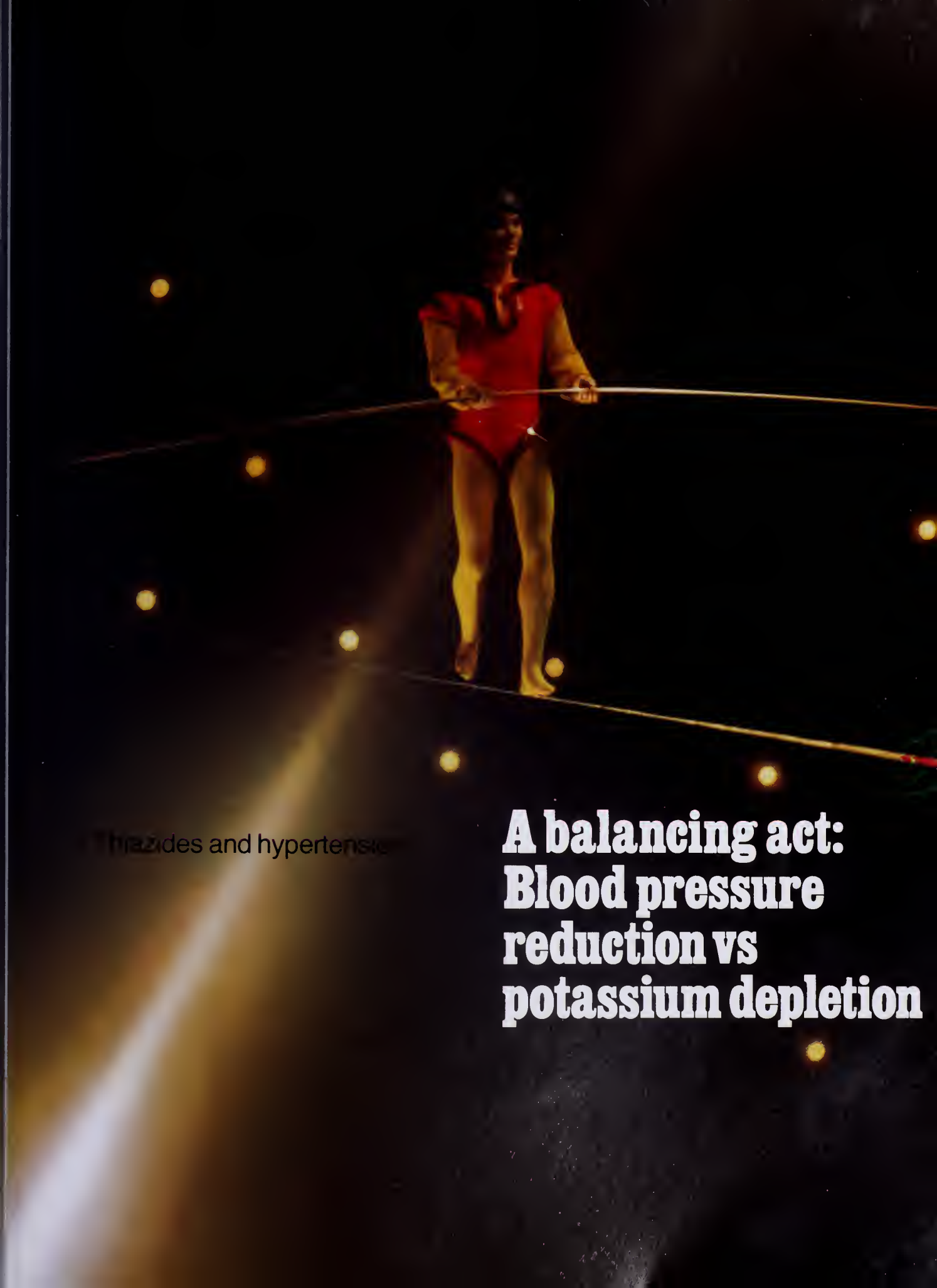
Initially, the parent who inflicted the abuse was considered to be either psychopathic, psychotic, or of very low intelligence. Reportedly common in these people were such sociological deviations as criminal activities, sexual promiscuity, alcoholism and unstable marriages. They were considered immature, impulsive, self-centered, hypersensitive and quick to react with poorly controlled aggression. In a number of cases, the family history gave the information that the parents themselves had been subject to violence from their own parents in their childhood.

As more information began to be gathered, it was realized that the beating of children was not confined to such obviously abnormal people. Such incidents also occurred among people with good education and stable financial and social backgrounds. In most cases it was found that there was always an immaturity of personality and some characterological defect. These individuals were poorly able to handle their sexual and aggressive impulses. Because of some lack of adequate identification in their own childhood, they had failed to develop that degree of maturity which ordinarily enables adults to abstract, symbolize and displace feelings of anger derived from minor day-to-day frustrations. Most of these abusing parents were unable to acquire such a capacity and struck directly at that which offended them. Sometimes the child was just a handy target because they were unable to reach the individual who truly had offended them, but often the child was the actual one, for important psychological reasons. For example, abusing parents might see in the child many of the traits and characteristics of the hated spouse. At times, the child itself may have been an unwanted one and a constant reminder of a very unhappy period in the parent's life. Sometimes the child might represent the parent himself or herself, and arouse strong feelings of anger that had remained in the individual since early childhood. Often there is a great deal of evidence to show that the abused child is both loved and hated.

The child would be talked about as if he or she were a saint, and at another time, as if a sinner. The child would be considered a genius, deeply intelligent and greatly gifted, and at another time, there would be complaints that the child was a monster who persecuted the mother or the father continually. This ambivalence was very definitely present in most of the child-abusing parents. For some, the child is experienced as the embodiment of their own instinctual drives, about which they feel extremely guilty and with which they cope very poorly in everyday living. Psychoanalytic studies of abusive parents have found frustrated orality, cruel anality and persistent mistrust, as characteristics.

A study done by Galdston[3] dealt with 23 families that had 42 children who had been abused by one or both of the parents. It is of interest that only one of the parents was diagnosed as being psychotic. The others fell into different categories such as phobic neurosis, and character disorder.

When children who had been the objects of violence in their own homes were studied, some remarkable findings came to light. It was found that the physically abused child was prone to develop violent behavior as a character trait because of his or her experiences. In the study by Galdston, the children themselves used violence in order to obtain the recognition or the attention of an adult. In other ways, their capacity to utilize aggression in ingenuity, in inventiveness, in curiosity or at play, was severely restricted. They were preoccupied in getting adult recognition to the exclusion of using aggressive forces in the service of other needs or desires. More was wanted than mere recognition by a word or gesture. Nothing short of firm, forceful holding of the child by the adult was sufficient to contain and calm the child's violence. This violent behavior which the children displayed appeared to be the expression of a desire for personal recognition by an adult, by means of the discharge of energy in the muscular makeup of the body. The second characteristic of the behavior of these children is aimlessness. This is a lack of recognizable purpose in the ways in which these children employ their bodies as a whole, as well as in relation to other persons and things. Sometimes it would appear as if the aimlessness had to do with ignorance about the objects at their disposal in the play area, such as slides, sandbox, and water; leaving them to these objects produced a period of perplexity and hesitancy. The aimlessness also seemed to have something to do with their own bodies and the children's awkwardness led to a suspicion of minimal brain damage. These children fell over themselves, ran into walls, did not know how to let themselves be held, nor how to position the head when they were told that they would be kissed. Under treatment, the children began to show increasing ability to use their motor capacity normally, and to act in response to their desires be-



Thiazides and hypertension

A balancing act: Blood pressure reduction vs potassium depletion

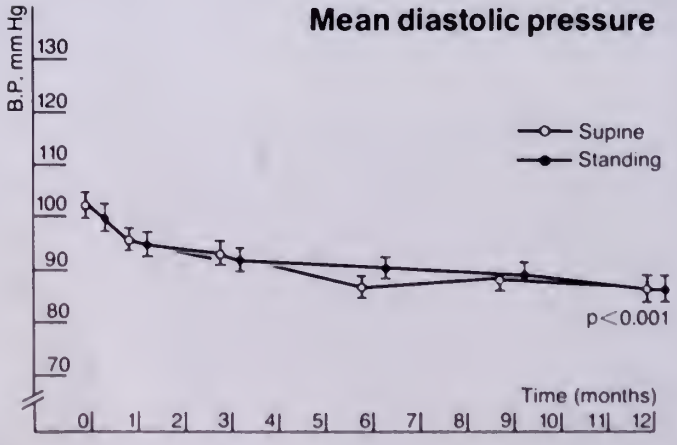
From a 1-year study of 18 patients with mild uncomplicated hypertension published in The Lancet*

Once a day

Naturetin®

Bendro-flumethiazide Tablets N.F.

Diastolic blood pressure down 12-15%



"The mean pretreatment blood pressure was 170/103 mmHg (supine) and 166/100 mmHg (standing). Diastolic pressure continued to fall over the first 6 months and then there was no further change up to 1 year...The mean blood pressure at 12 months was 153/88 mmHg (supine) and 142/88 mmHg (standing)."

"The patients were receiving a single daily dose of 10 mg bendrofluazide [bendroflumethiazide]...there were no apparent side effects from the medication."

*Wilkinson PR et al. The Lancet 1 759-762. 1975.



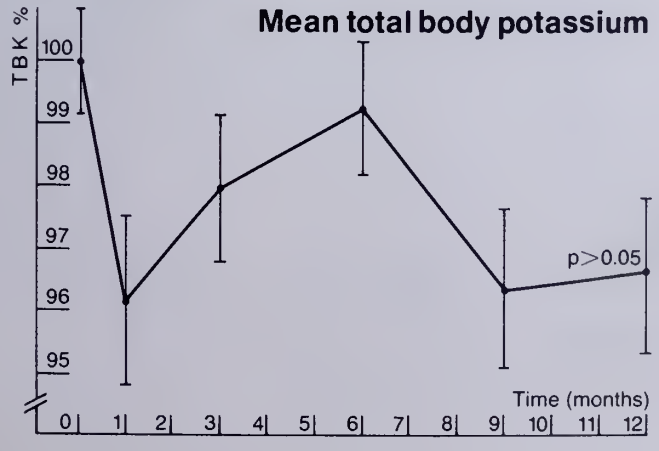
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Naturetin®

Bendro-
flumethiazide
Tablets B.P.

2.5, 5 and 10 mg

Potassium stabilized at 96% mean TBK



"The amount of potassium loss during the period of study did not seem to be clinically significant."

"A serum potassium of less than 3.5mmol per litre is often taken as the value below which potassium supplements should be given...At an arbitrary lower value for serum potassium of 3.0mmol per litre, few patients, our data suggest, would need potassium supplements. Our findings with TBK support this view..."

See next page for full prescribing information.

Once a day
Naturetin®
Bendroflumethiazide Tablets N.F.

NATURETIN®-2.5
NATURETIN®-5
NATURETIN®-10
Bendroflumethiazide Tablets N.F.

DESCRIPTION

Naturetin (Bendroflumethiazide Tablets N.F.) is a benzothiadiazine derivative containing a benzyl and a trifluoromethyl group. It is a potent oral diuretic and antihypertensive agent available as compressed tablets providing 2.5, 5.0, or 10 mg. bendroflumethiazide.

ACTIONS

The mechanism of action results in an interference with the renal tubular mechanism of electrolyte reabsorption. At maximal therapeutic dosage all thiazides are approximately equal in their diuretic potency. The mechanism whereby thiazides function in the control of hypertension is unknown.

INDICATIONS

Naturetin (Bendroflumethiazide Tablets N.F.) is indicated as adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis and corticosteroid and estrogen therapy.

Bendroflumethiazide has also been found useful in edema due to various forms of renal dysfunction such as: nephrotic syndrome, acute glomerulonephritis, and chronic renal failure.

Naturetin (Bendroflumethiazide Tablets N.F.) is indicated in the management of hypertension either as the sole therapeutic agent or to enhance the effectiveness of other antihypertensive drugs in the more severe forms of hypertension.

Usage in Pregnancy. The routine use of diuretics in an otherwise healthy woman is inappropriate and exposes mother and fetus to unnecessary hazard. Diuretics do not prevent development of toxemia of pregnancy, and there is no satisfactory evidence that they are useful in the treatment of developed toxemia.

Edema during pregnancy may arise from pathological causes or from the physiologic and mechanical consequences of pregnancy. Thiazides are indicated in pregnancy when edema is due to pathologic causes, just as they are in the absence of pregnancy (see WARNINGS). Dependent edema in pregnancy, resulting from restriction of venous return by the expanded uterus, is properly treated through elevation of the lower extremities and use of support hose; use of diuretics to lower intravascular volume in this case is illogical and unnecessary. There is hypervolemia during normal pregnancy which is harmful to neither the fetus nor the mother (in the absence of cardiovascular disease), but which is associated with edema, including generalized edema, in the majority of pregnant women. If this edema produces discomfort, increased recumbency will often provide relief. In rare instances, this edema may cause extreme discomfort which is not relieved by rest. In these cases, a short course of diuretics may provide relief and may be appropriate.

CONTRAINDICATIONS

Bendroflumethiazide is contraindicated in anuria.

It is also contraindicated in patients who have previously demonstrated hypersensitivity to it or other sulfonamide-derived drugs.

WARNINGS

Bendroflumethiazide should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may be additive or may potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Usage in Pregnancy. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers. Thiazides appear in breast milk. If use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS

Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: dryness of the mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop with thiazides as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity.

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Latent diabetes mellitus may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

ADVERSE REACTIONS

Gastrointestinal System: anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), and pancreatitis. *Central Nervous System:* dizziness, vertigo, paresthesia, headache, and xanthopsia. *Hematologic:* leukopenia, agranulocytosis, thrombocytopenia, and aplastic anemia. *Dermatologic-Hypersensitivity:* purpura, photosensitivity, rash, urticaria, and necrotizing angiitis (vasculitis, cutaneous vasculitis). *Cardiovascular:* orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates or narcotics. *Other:* hyperglycemia, glycosuria, occasional metabolic acidosis in diabetic patients, hyperuricemia, allergic glomerulonephritis, muscle spasm, weakness, and restlessness.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

DOSAGE AND ADMINISTRATION

Therapy should be individualized according to patient response. This therapy should be titrated to gain maximal therapeutic response as well as the minimal dose possible to maintain that therapeutic response.

Diuretic. The usual dose is 5 mg. once daily, preferably given in the morning. To initiate therapy, doses up to 20 mg. may be given once daily or divided into two doses. A single daily dose of 2.5 to 5 mg. should suffice for maintenance.

Alternatively, intermittent therapy may be advantageous in many patients. By administering the preparation every other day or on a three to five day per week schedule, electrolyte imbalance is less likely to occur; however, the possibility still exists.

In general, the lowest dosage that achieves the therapeutic response should be employed.

Antihypertensive. The suggested initial dosage is 5 to 20 mg. daily. Maintenance dosage may range from 2.5 to 15 mg. per day, depending on the individual response of the patient. When the diuretic is used with other antihypertensive agents, lower maintenance doses for each drug are usually sufficient.

STORAGE

Store at room temperature, avoid excessive heat.

HOW SUPPLIED

2.5 mg. tablets in bottles of 100, 5 mg. tablets (scored) in bottles of 100 and 1000, and 10 mg. tablets (scored) in bottles of 100.

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yond the mere recognition and affirmation of their existence by an adult. They did come to display initiative, imagination, innovation, and the capacity to play. More than that, they were able to ask for adult attention to some part or function of their being, rather than to the totality of their existence.

The first requirement of management is the recognition that a child is being physically abused. This, as soon as it is recognized, must be reported either to the County Welfare Office, to a social agency that works with children, to a family service agency, or to the police. Every one of the 50 states now has a law requiring this to be done and setting penalties if it is not done. No one, physician, nurse, neighbor, social worker, minister, need worry about being involved in legal or other difficulties, if he or she makes such a report.[2]

When this syndrome was first recognized as a definite entity and correctly ascribed to the cause, the first efforts were directed toward punishment and criminal prosecution of the parents. This did very little good, whether the criminal prosecution resulted in a jail sentence or in a fine. When the guilty parent returned home, obviously his or her feelings toward the child had not changed, but in many cases had worsened, and the child suffered further abuse. The next effort was to remove the child from the family and place the child in a foster home or an orphanage or a similar child-caring institution. It was realized, by continuing the study of the family minus the child, and of the child in its placement, that neither of them did particularly well. It was decided after a number of years of study that criminal prosecution was of very little value, since available facilities were extremely limited and were not set up to care for the violent behavior that many of these children manifested.

Finally, the conclusion was arrived at, that if treatment were to be effective, the family must be regarded as a unit, and the abusive cycle must be broken completely. Removal of the battered child did not guarantee that the parents would seek help for themselves, and this was the ultimate goal in any program dedicated to curbing child abuse. The reasons are simple. There might be other children in the family that had not as yet been abused but who might become future targets. Even if there is only one child and this child was removed, there might be other children born who could also be abused.

For the above reasons, we have progressed to the point of recognizing that abusing parents have severe emotional problems that need to be worked out. The primary objective became the rehabilitation of the family as a viable unit. The principle of protective intervention became formalized, and this avoids placing any individual blame on the parents, and attempts to help him or her provide optimal care for the child.[4] It was found that child care centers and community mental health centers appear to offer the most promise in this respect. These centers could provide a degree of separation from the parents for several hours five days a week, and this could be done without actually terminating the parent-child relationship. The child would be safe and could receive treatment during this time, and the parents also would be offered professional help and guidance. Such centers are increasing in number and are doing good work. In addition, there has been much interest in an organization called Parents Anonymous (PA). There are now more than 150 chapters of this organization in the United States, Canada, Australia, and Guam. I think that such an organization is an excellent auxiliary to more professional treatment of the abusive parent as well as the abused child.

At any rate, with this unhappy phenomenon out in the open recognized not only by physicians but by the public in general, we can hope for more effective ways to treat the abused child and the abusing parents and to be able to do preventive work, so that a parent recognizing uncontrolled anger toward his or her child will know that there is help available.

★★★

102 Lynnwood Circle (39401)

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The Acute Afferent Loop Syndrome

WILLIAM O. BARNETT, M.D., JIMMY L. HAMILTON, M.D., and HUGH A. GAMBLE, II, M.D.

Jackson, Mississippi

BILLROTH II gastrojejunostomy, in the restoration of alimentary tract continuity after gastric resection, creates an afferent loop which functions to drain bile, pancreatic juice and succus entericus into the stomach. Obstruction of this loop may result from volvulus, kinking, internal hernia, jejunogastric intussusception or cicatricial occlusion from marginal ulceration.

Pathophysiology

Occlusion of the afferent loop between the duodenal stump and the stomach creates a closed loop of obstructed bowel. Impending catastrophe is assured because of mounting pressure resulting from the continued inflow of bile and pancreatic juice. The loop becomes progressively more distended and may assume huge proportion. Eventually, the intraluminal pressure exceeds the venous pressure in the wall of the duodenum and impairment of circulation to the loop supervenes. These high pressure levels in the loop are also instrumental in the development of an elevated blood amylase level in many instances. Without decompression, gangrene, perforation of the loop, peritonitis and death can be expected.

Diagnosis

The acute afferent loop syndrome is considered, of course, only in those patients who have had a Billroth II type gastrojejunostomy. Severe upper abdominal pain of a continuous, unrelenting nature is characteristic. Nausea and vomiting usually occur and the vomitus virtually never contains bile. Fever, tachycardia and shock may also characterize these patients. A palpable abdominal mass may be demonstrated, but this is usually not the case. Abdominal tenderness is frequently present. Upper radiologic gastrointestinal examination has, in our experience, been most helpful in ruling out other conditions. There are many instances recorded in the literature in which a diagnosis of acute pancreatitis was mistakenly entertained because of the elevated amylase. This error must be avoided if maximal chances for recovery are to be afforded.

Billroth II gastrojejunostomy creates an afferent loop which functions to drain bile, pancreatic juice and succus entericus into the stomach. The authors discuss the obstruction of this loop, its various causes, pathophysiology, diagnosis, and treatment. A report of an unusual case concludes the paper.

Treatment

The objective of therapy is to effect surgical decompression of the loop before gangrene has occurred. The specific procedure employed will vary depending upon the mechanism of obstruction and the stage at which operative relief is employed.

Internal Hernia. Following the establishment of a Billroth II gastrojejunostomy, a potential hiatus is created between the stomach and the efferent loop anteriorly, and the colon and mesocolon posteriorly. The afferent loop may herniate through this defect, become entrapped and suffer occlusion of its lumen as well as embarrassment to its blood supply. The indicated operative maneuver is to reduce the herniated loop and close the defect.

Stricture or Kinking. Obstruction of the afferent loop usually occurs at the junction between this bowel limb and the stomach. Relief can be provided immediately by side-to-side anastomosis of the afferent and efferent loops (see Figure 1). This maneuver may predispose to later marginal ulceration because of shunting of alkaline bowel content away from the gastrojejunostomy stoma. However, in these desperately ill patients, we think that relief of the obstruction is the paramount concern of the moment and later complications may be dealt with under more favorable circumstances.

From the Department of Surgery, University of Mississippi Medical Center, Jackson, MS.

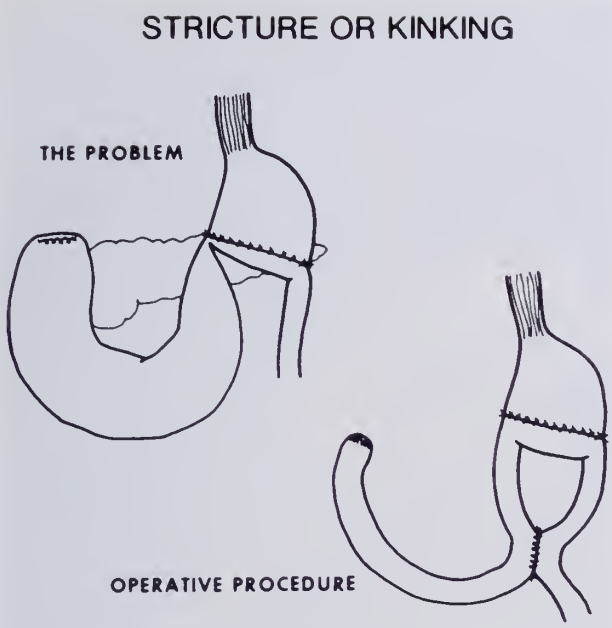


Figure 1. Enteroanastomosis of afferent and efferent loops when segments are viable.

Gangrene of the Afferent Loop. Sustained and increasing intraluminal pressure will eventually lead to duodenal gangrene. The duodenum tolerates this stress less effectively than does the jejunum and ileum because of the arrangement of intramural veins. In most instances duodenal gangrene is not total, with viability being preserved in that portion which drains the pancreas and the common bile duct (see Figure 2). Resection of the dead bowel and anastomosis to a Roux-en-Y limb of jejunum constitutes the operative procedure of choice.

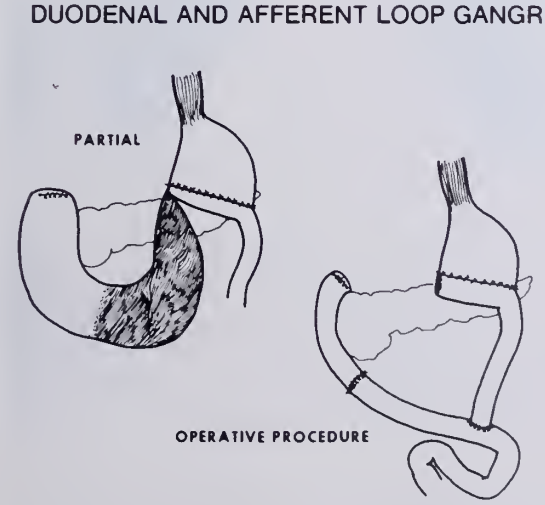


Figure 2. Partial gangrene necessitates resection with anastomosis of viable duodenal segment to the jejunum.

With total duodenal gangrene, a much more severe operative challenge must be faced. The following case report illustrates such a circumstance.

Case Report

F.H., a 52-year-old male, had sustained a gastric resection some two years previously for a malignant tumor of the stomach. On this occasion, he was admitted with upper abdominal pain, nausea, vomiting, and fever. The blood amylase was markedly elevated. Exploratory laparotomy revealed gangrene of the entire afferent loop and duodenum. These gangrenous tissues were removed. During the operative maneuvers, a large volume of black fluid issued forth from an area of full thickness necrosis in the wall of the devitalized bowel. The systolic blood pressure dropped to 40 mm Hg. Shortly after aspiration of this foul-smelling material and thorough irrigation of the peritoneal cavity, his blood pressure returned to normal. Biliary and pancreatic drainage was provided by the construction of separate Roux-en-Y limbs of jejunum (see Figure 3). The patient recovered.

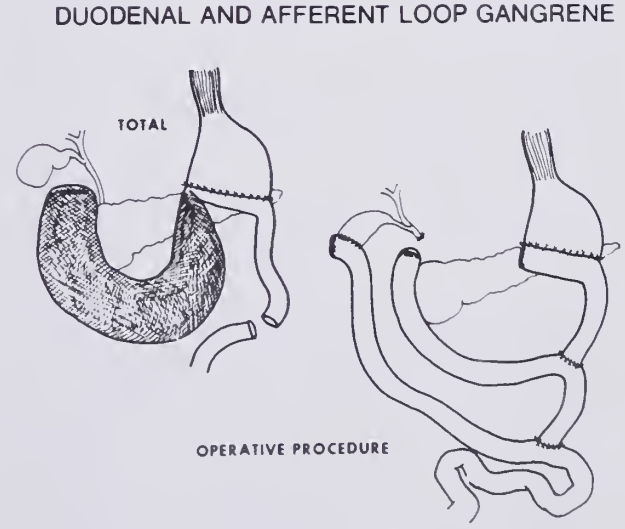


Figure 3. Entire duodenum and afferent loop must be removed when gangrene is total.

Our examination of the available literature failed to reveal another incidence of survival following gangrene of the entire duodenum and afferent loop.

★★★

2500 North State Street (39216)

Radiologic Seminar CLXXVIII: The Air-Fluid Level in the Retrocardiac Space

WALTER T. COLBERT, M.D.
Natchez, Mississippi

THE PRESENCE OF a gross air-fluid level in the retrocardiac zone on a routine chest x-ray can be a dramatic demonstration of a significant abnormality with relatively serious potential. This finding is frequently encountered in otherwise asymptomatic patients on a routine chest examination. The finding in question almost always represents a large hiatus hernia. A very rare type of hiatus hernia which can present in this manner is the paraesophageal type.

Case Report

This 75-year-old female was admitted to the hospital for complaints unrelated to the chest or upper gastrointestinal tract. On routine chest x-ray a large air-fluid level was noted in the retrocardiac zone (see Figure 1). An esophagram and upper GI series on another patient better demonstrates a hiatus hernia of the paraesophageal type, with the distal stomach in the patient's chest (see Figure 2). The rather large hiatus hernia in this patient was essentially asymptomatic, and no definitive therapy was indicated.

The paraesophageal hiatal hernia differs from the sliding hiatal hernia in that the symptoms are mechanical from protrusion of the stomach. The esophagogastric junction usually remains fixed and competent at or near its normal position (see Figure 2). The fundus or anterior wall of the stomach herniates into the chest in a complete peritoneal sac through the anterior and lateral portion of the hiatus, resulting in a true "upside-down stomach." These hernias may become large and are subject to mechanical complications. Paraesophageal hernias may be present without symptoms for extended periods of time, but carry a high mortality from catastrophic complications. Having a complete peritoneal sac, this type of hernia carries a definite risk of torsion or volvulus, obstruction, and strangulation.

When the hernia becomes large enough, the entire stomach is drawn into the chest and the colon, omentum, small intestine, and spleen may also enter the hernia sac.

Bleeding from an ulcer or gastritis in the incarcerated gastric pouch may be severe enough to require blood transfusion.

When the incarceration, obstruction, ulceration, or strangulation occurs, symptoms of pain and the inability to vomit become severe. Combined para-



Figure 1. Routine erect PA chest film demonstrating a gross air-fluid level seen through the cardiac shadow and projecting moderately to the right of the cardiac outline.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Jefferson Davis Memorial Hospital, Natchez, MS.



Figure 2. Esophagram and upper GI film. Note esophagogastric junction (arrow) in normal position and distal stomach herniated above the diaphragm in a paraesophageal location.

esophageal and sliding hernias give rise to symptoms and complications of reflux in addition to those of mechanical protrusion of a large portion of the stomach through the hiatus.

The diagnosis of paraesophageal hiatal hernia can often be made from a plain x-ray of the chest (see Figure 1) on the basis of a retrocardiac mass or the presence of an air-fluid level. The diagnosis can be established by the esophagram and upper GI series. A large lung abscess, a loculated pleural effusion with an air-fluid level, or other rare intrapulmonary abnormalities could conceivably produce such an appearance but these rare causes of an air-fluid level in the retrocardiac zone can be excluded by the contrast examination.

Summary

A gross air-fluid level projected in the retrocardiac zone will almost always represent a large hiatus hernia. A very rare type is the paraesophageal hiatal hernia. The diagnosis can be established with certainty by the esophagram and upper GI contrast study. ★★★

P. O. Box 1488 (39120)

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LEGEND OF ST. VALENTINE

The first Valentine was sent in the third century A.D. by a young Roman named Valentinus. Because he was a Christian and would not give up his dedication to Christ, he was sentenced to death by the worldly Emperor Claudius II. While the imprisoned Valentinus awaited his execution, he became the teacher and friend of the jailer's blind, pretty, young daughter, Julia. Legend tells that, through faith, he restored her sight.

On the night before he was to be put to death, he wrote a farewell to the girl and signed it "From your Valentine." On the next day, February 14, 270 A.D., he was executed. It is said that Julia planted a pink blossoming almond tree near his grave, as a symbol of abiding love and friendship. And on each February 14, messages of affection, love and devotion are exchanged around the world in keeping with the beautiful spirit of St. Valentine.



The President Speaking

Congress and Medicine: 1977 Was a Good Year

JAMES O. GILMORE, M.D.
Oxford, Mississippi

Despite a hard-line attitude among many wielders of political power and influence in Washington, every major Congressional move against medicine in 1977 was defeated, stalled, or defanged.

The achievements reflected not only the AMA's vigor in Washington but its amplified communication and liaison with component societies, specialty societies, other health-care organizations, insurers, and businessmen.

Defeated were:

- A clear-cut Congressional sanction for Federal Trade Commission jurisdiction over nonprofit organizations, including medical societies. Denial of that sanction means the FTC's current forays against physicians and their organizations remain subject to the kind of challenge that the AMA has mounted.
- Subjection of physicians' offices to certificate-of-need programs, as called for in several versions of hospital "cost-containment" proposals.

Stalled were Administration proposals for price controls on hospitals and a fixed national dollar limit on capital expenditures of health institutions.

Defanged was H. R. 3, the Medicare-Medicaid Anti-Fraud and Abuse Amendments signed into law by President Carter as P. L. 95-142.

The AMA federation supported the basic fraud and abuse control principle of H. R. 3 but successfully achieved such modifications as these:

- The definition of "shared health facilities"—originally encompassing almost all group practices—is narrowed more closely to the originally intended "medicaid mills" and the like. The practitioner and groups of practitioners are generally exempted from H. R. 3's cumbersome reporting and disclosure requirements.
- Medicare-Medicaid review programs duplicating those of PSROs are waived, provided the latter are found to be performing their duties effectively. Also, authority for "program review teams" to evaluate medical care—duplicating PSRO review—is repealed.
- The period for PSRO's conditional status, and the starting time for ambulatory-care review under PSRO, are extended.

Those are just a sample of the changes the federation achieved in H. R. 3—but they symbolize the complexity of its many annual legislative tasks.

In 1977 the AMA stepped up its liaison with both Congress and the White House, and the AMA and all parts of the federation worked closer than ever on these critical issues to achieve these legislative results.

Organized medicine will face many critical legislative issues in 1978, including amendments to the Planning Act, many other Public Health Service programs, and national health insurance. Medicine must continue to pull together on legislation in order to protect physicians and patients from legislative acts that would reduce the quality of medical care, increase costs, or reduce access.

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XIX, NUMBER 2
FEBRUARY 1978

The Escalating Cost of Medical Care Everyone Has a Solution: No One Has the Answer

A situation as complex as this cannot easily be solved. With demands for better and more comprehensive care it is not easy to reduce costs. With third party payment for the majority of hospital care, it is easy to see how demands will not decrease. While there are many contributing factors to be considered, a signficant deductible insurance policy and accountability on the part of the physician are by far the most outstanding.

Utilization committees have significantly reduced hospital stays. Hospitals that were previously overcrowded now welcome patients.

It seems only a short time ago that the diagnosis of peptic ulcer disease was limited to the ears and hands, and in the hands of astute physicians, the diagnosis was surprisingly accurate. Differentiation between gastric and duodenal ulcer was more difficult, but the rewards are poorly productive, in that we have done little in increasing the longevity of gastric cancer patients. Monitoring the healing of ulcers by x-rays adds little to the well-being of the patient, whether healed or unhealed, except in the case of stress or drug induced ulcers, the patient still has a "sick" upper GI tract and remains the same, emotionally and physically.

So after consideration of increasingly deductible policies with accompanying loss of the incentive for overutilization by patients, we must begin to consider accountability on the part of the physician.

How negligent is a physician who treats a patient with classic symptoms and signs of peptic ulcer without benefit of laboratory, x-rays or endoscopy? This, of course, is over-simplification at its worse but we must begin to consider how much is really necessary.

W. Moncure Dabney, M.D.
Editor
Crystal Springs, MS

Medico-Legal Brief

Missed Checkup a Defense In Medical Malpractice Suit

The failure of a mother to return her newborn infant to a hospital clinic for a checkup, as instructed, was a valid defense to the child's suit against a physician and the hospital for failure to diagnose septicemia, a Michigan appellate court ruled.

On June 3, 1970, two days after the child's birth in the hospital, a complete examination of the child indicated that he was jaundiced. His bilirubin count was 9.77 mg. The next day the bilirubin count decreased to 5.0 mg. and the child was discharged from the hospital. The child was readmitted 13 days later, with severe septicemia. His bilirubin count then was 41.8 mg. The child was sent to a children's hospital for blood exchange transfusions and antibiotics, but permanent injury allegedly resulted.

The mother, in the child's name, sued an attending physician in the hospital's baby clinic and the hospital for failing to diagnose septicemia between the time of the child's initial discharge and his readmission 13 days later.

During the trial, the mother testified that four days after the child's release he became ill. The mother said she called the baby clinic on June 8, 1970, and the physician told her to change the baby's formula. She said on June 10, 1970, she brought the baby to the clinic. She said the physician did not examine the baby and advised resumption of a prior formula.

The physician testified that the child was not

brought to the hospital between the initial discharge and the readmission 13 days later and that the mother was instructed by phone to bring the child to the hospital or to the children's hospital if his condition did not improve. The hospital and the physician raised the defense of contributory negligence on the part of the mother for failing to follow the physician's orders. A jury verdict finding no cause of action was entered in favor of the physician and hospital.

The parents appealed, claiming that it was improper for the trial court to consider the contributory negligence of the mother, since the child was the person suing.

The appellate court disagreed and upheld the trial court ruling. The issue of the contributory negligence of the mother was relevant to the question of whether the septicemia was not diagnosed or whether the mother's failure to bring the child to the hospital prevented the diagnosis from being made, the court said.—*Dowdell v. Crittenton Hospital,* 254 N.W.2d 876 (Mich.Ct. of App., May 2, 1977)

Journal MSMA Scores High in Readership Survey

Journal MSMA scored highest in a recent readership survey of state medical journals chosen on the basis of size and geographic location. The readership survey was conducted by an independent national firm and included 10 state medical journals.

The survey found that state medical journals are well read. An average state medical journal is read by 79 per cent of its audience each issue and 96 per cent are read at least one of four issues.

In Mississippi, *Journal MSMA* is read by 83 per cent of its audience each issue and 97 per cent read at least one of four issues.

As for advertisements, some 60 per cent of the readers of state medical journals say they pay attention to advertisements regularly or occasionally. In Mississippi 74 per cent of *Journal MSMA* readers pay attention to advertisements regularly or occasionally.

A total of nine of ten readers responding to the survey want to continue receiving their state medical journal and readers spend almost one-half hour reading their journal.

States included in the survey were Arizona, Connecticut, Indiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri and Texas.

PERSONALS

AFZAL AHMED and Mrs. Ahmed were honored with a reception at the Terry Community Center. Dr. Ahmed is in practice at the Terry Medical Clinic.

ELDON L. BOLTON of Biloxi has been elected chief of staff at Howard Memorial Hospital for 1978. THERESA L. R. BUCKLEY was re-elected president of the medical staff of the hospital. Other medical staff members elected were WILLIAM PONTIUS, secretary-treasurer; RICHARD FURR, chief of medicine; RAY WESSON, chief of surgery; MAX CURRY, chief of pediatries; ROBERT MIDDLETON, chief of family practice; and ERIC CHRISTMAN, chief of ob-gyn.

WALTER T. BOONE, RICHARD G. HUTCHINSON, G. B. SHAW, and JAMES TATE THIGPEN, all of Jackson, have been elected Fellows of the American College of Physicians.

JOHN W. BOWLIN of Tupelo, ROBERT P. HENDERSON of Jackson and JOHN D. MORGAN of McComb were on the program for the 22nd annual Tri-State Thoracic Consecutive Case Conference at Biloxi last month, according to RICHARD T. FURR of Ocean Springs, Mississippi Thoracic Society president.

THERESA BUCKLEY of Biloxi has been appointed co-chairwoman of the 1978 Heart Fund campaign for East Harrison County.

C. DUANE BURGESS, GATHEL O. RUNNELS, GERALD M. ROBERTSON and GEORGE E. WILKERSON of Hattiesburg announce the new location of their clinic, Hattiesburg Psychiatric Group, P.A., to 2403 Mamie Street.

JOHN D. CHAPMAN of Yazoo City has been elected president-elect of Central Medical Society. CHARLES HOGUE of Yazoo City was elected vice president.

SIDNEY A. CHEVIS of Bay St. Louis announces the association of J. D. RUTHERFORD, III, for general practice at 644 Dunbar Avenue.

GRACE R. FERGUSON, formerly of Houston, TX, has been appointed clinical director of the Gulf Coast Mental Health Center. Dr. Ferguson received her M.D. degree from the University of Utah School of Medicine.

LEWIS HATTEN of Hattiesburg is a recent enrollee in the Medical Alumni Guardian Society of the University of Mississippi Foundation.

HARRY BRAD HEITZMAN of Ocean Springs has been certified by the American Board of Internal Medicine.

PURVIS WILLIAM HILL, JR., of Clarksdale has opened his offices in Executive Plaza for the practice of surgery and was recently honored with a reception by the Clarksdale-Marks alumnae of Delta Sigma Theta Sorority, Inc.

EDLEY JONES, SR., of Vicksburg was a member of the special committee which planned the celebration of the 60th anniversary of the Vicksburg Rotary Club and published a history of the club.

JOHN C. LONGEST of Starkville has been elected chairman of the Board of Directors for the National Interagency Council on Smoking and Health.

KIMBLE LOVE of Vicksburg has been named medical advisor to the Board of the Warren County chapter March of Dimes.

FRANK G. MARTIN has associated with the Gulf Coast Surgical and Diagnostic Center, P.A. for the practice of surgery with offices located at Medical Plaza, Vancleave Road in Ocean Springs.

ALFIO RAUSA of Greenwood has been elected secretary of the American Association of Public Health Physicians at their annual meeting in Washington. He was also appointed associate editor of the organization's bulletin.

SAMUEL J. SIMMONS, III, announces the relocation of his office for the practice of internal medicine to Suite 107, Doctors Plaza, 4211 Hospital Road in Pascagoula.

TATE THIGPEN of Jackson is serving as District Lt. Governor for Optimist International.

BILL THORNTON of Meridian has been elected second vice president of the Greater Meridian Chamber of Commerce for 1978. Dr. Thornton is also serving as chief of staff of Jeff Anderson Memorial Hospital.

LETTERS

SIRS: One of the puzzling dilemmas of our technological times is that frequently when we approach a problem we cannot be sure that the "cure" is not worse than the problem itself. The present controversy of the ravages of the fire ant through the southern states versus the possible hazards of the insecticide Mirex is just such a dilemma. Since Mirex is at present the most effective control measure against the spreading fire ant, this kind of technological problem remains sharply in focus.

Intrigued by the puzzle, I would like to survey my fellow physicians and health services personnel of the states affected by the fire ant problem as to their findings regarding either or both horns of this particular dilemma. To this end, I would greatly appreciate answers to the following series of questions by all those in the know who have time and energy to spare to the problem:

1. How many individuals have been stung by fire ants in your area, region, or state? Can you estimate a probable number? State sex.
2. What kind of reactions to fire ants have you seen? Local reactions? How great was the swelling? Larger than an inch? Larger than 4 to 6 inches? Did swelling involve a joint? More than 1 joint? Systemic reactions? What symptoms? (Wheezing, hives, angioedema, urticaria, laryngeal edema) How soon did symptoms occur? How long did they last? Superimposed infection? Does this occur often? Are such infections severe?
3. Have patients reacting to fire ants required hospitalization? If so, how many and for approximately how long?
4. To your knowledge, have there been any fatalities from fire ant stings in your area, region, or state. If so, how many? Could you provide details?
5. If you have any case histories of reactions to fire ant stings, they would be greatly appreciated. They should include age, sex, race, symptoms, treatment, and outcome.
6. Have you any knowledge as to the success or failure of hyposensitization to fire ant venom? If so, details would be appreciated.
7. To your knowledge have there been any cases of Mirex poisoning and/or illness attributed to the use of Mirex in your area, region, or state? If so, could you provide information about such incidents? Case histories, if available, about such illness would be greatly appreciated. They should include age, sex, race, symptoms, treatment and outcome.
8. Have you a personal opinion about this particular problem? Do you believe the possible hazards of fire ants outweigh the possible hazards of the use of Mirex? Or vice versa.

CLAUDE A. FRAZIER, M.D.
Doctor's Park—Bldg. 4
Asheville, NC 28801

LETTERS / Continued

SIRS: *H. influenzae* is one of the most important species involved in bacterial infections of childhood. Meningitis is the most important clinical entity caused by *H. influenzae,* type b and this species is the most frequent cause of acute bacterial meningitis in infants and children between the ages of 1½ and 36 months. The peak age-incidence is 8-10 months with rapid decline after 3 years of age, becoming rare after 5 or 6 years.

Bacterial meningitis is an acute medical emergency. Delay in treatment invites neurologic disability or death. This agent should always be considered and suspected in the most susceptible age group. A high index of suspicion is necessary for diagnosis. Treatment at the earliest possible time is of paramount importance. Signs and symptoms are variable. Older children may present with classical signs and symptoms while infants may show no more than slight fever, convulsions, vomiting and alternating irritability and somnolence.

Ampicillin and chloramphenicol are the drugs of choice. In view of the fact that ampicillin resistant strains of *H. influenzae,* type b have been reported in Mississippi, it is urgently recommended that therapy be started with both drugs and continued, at least until the sensitivity tests indicate the suitability of ampicillin alone. It is the practice at the University Medical Center Children's Hospital to use the same combined therapy in an infant or child with clinical and CSF findings of bacterial meningitis but without an immediately identifiable organism and in whom *H. influenzae* is considered to be a likely etiologic agent. The recommended combined therapy is:

Ampicillin 400 mg/kg/day, divided into 6 doses and given every 4 hours I.V.; and

Chloramphenicol 100 mg/kg/day divided into 4 doses and given every 6 hours I.V.

If the organism is found to be sensitive to ampicillin, the chloramphenicol is discontinued and the ampicillin maintained intravenously for 21 days in the infant under 3 months of age or 10 days in the child over 3 months of age.

If the organism does not grow the child is maintained on both drugs for the full course of therapy. The failure to grow the organism from blood or spinal fluid is a common problem in the child who has been partially treated.

In the child requiring therapy with chloramphenicol, blood counts, three times a week, should be done. Should there be a drop in total WBC's or hematocrit or if the polys drop below 30 per cent a bone marrow should be obtained for evaluation as to possible chloramphenicol-toxicity.

Other principles of management of any CNS infection such as fluid restriction and careful monitoring of electrolytes should be carried out.

Forty-eight hours after the completion of the child's intravenous therapy a repeat spinal puncture is done. At that time a cell count of more than 8 polys, regardless of the total count, is considered an indication for an additional 24 hours of observation and a repeat tap. The total CSF white cell count should not exceed 60 cells/MM^3. CSF sugar and protein will have returned to normal. Observation must be continued for 2-3 weeks since relapses may occur.

The case fatality ratio is about 5 per cent. Treatment should aim for both survival and the prevention of the more subtle forms of CNS damage.[1] Secondary cases have been suggested to occur at about the same rate as for meningococcal meningitis in household contacts,[2] however, appropriate antibiotic regimens have not been established.[3] It appears, therefore, that close observation of household contacts of the same age or younger than the patient should be continued for a period of 30 days from onset of the original case.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health

References

1. Baine, W. B.: Bacterial Meningitis. Current therapy, 46-53, 1977.
2. Ga. Dept. of Human Resources, Phys. Rep., April, 1977.
3. MMWR (CDC) 26:201, June 24, 1977.

NEW MEMBERS

BORRELL, LUIS, Meridian. Born Managua, Nicaragua, Dec. 16, 1940; M.D., Facultad de Medicina y Cirugia de la Universidad Nacional de Nicaragua, Leon, 1966; interned Charity Hospital, New Orleans, LA, one year, 1970-71; medicine residency, Veterans Hospital, New Orleans, 1971-73; pulmonary disease residency, New Orleans, 1973-75; elected by East Mississippi Medical Society.

CHAPPELL, JOSEPH J., JR., Tupelo. Born Washing-



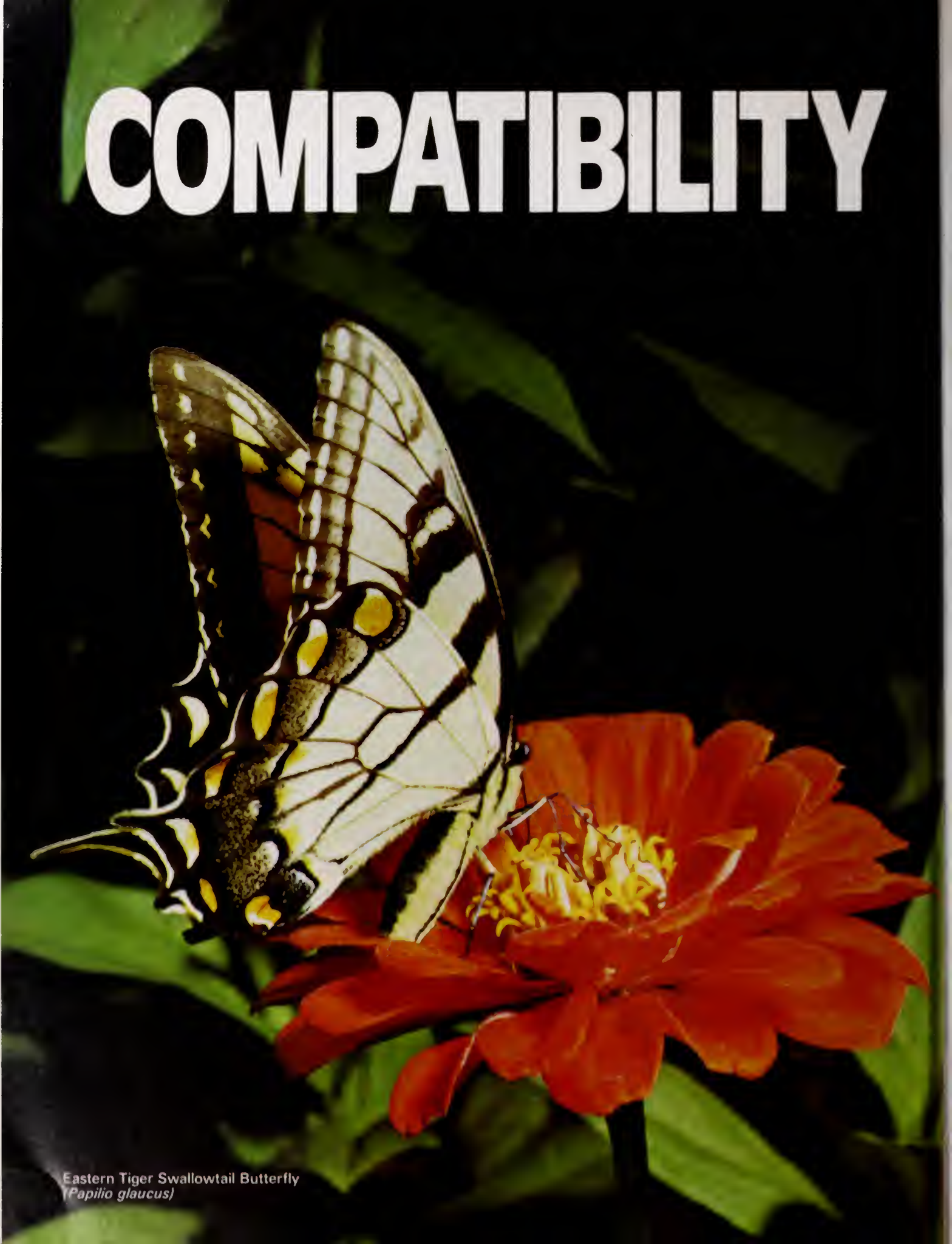
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COLACE works by stool-softening action alone, free from laxative stimulation. Simply by letting natural intestinal water permeate stools, COLACE helps to eliminate the hard, dry stools common to constipation.

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COMPATIBILITY



Eastern Tiger Swallowtail Butterfly
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Does it influence your choice of a peripheral/cerebral vasodilator*?

Vasodilan–compatible with coexisting diseases (e.g., glaucoma, diabetes)

Vasodilan has not been reported to affect the course of coexisting disease; it has not been reported to affect blood sugar levels or to raise intraocular pressure.

Vasodilan–compatible with concomitant therapy

Vasodilan has not been reported to affect the treatment of coexisting disease; it is compatible with such drugs as hypoglycemics and miotics.

Vasodilan–compatible with your total regimen for vascular insufficiency

Vasodilan can be a valuable adjunct in planning a total therapeutic program for vascular insufficiency.

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836



VASODILAN® 20-mg tablets

(ISOXSUPRINE HCl)

20 mg q.i.d. recommended dosage

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Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- high theophylline for effective around-the-clock therapy
- 100% free theophylline
- individualized theophylline dosage schedule

Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.

Dosage: Initial: Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours, children 8-12: 1 tablespoonful or one capsule every 6-8 hours and children under 8: 3 to 5 mg theophylline/kg body weight every 6-8 hours. Theophylline dosage may be cautiously increased to 2000 mg/24 hr in adults or 7 mg/kg in children; monitoring of serum theophylline levels at higher dosages is recommended.

Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20μg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

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ton, DC, Nov. 17, 1943; M.D., Emory University School of Medicine, Atlanta, GA, 1973; interned Grady Hospital, Atlanta, one year; ophthalmology residency, same, 1974-77; elected by Northeast Mississippi Medical Society.

CROWDER, HERMAN R., III, Jackson. Born Yazoo City, MS, Sept. 13, 1943; M.D., Tulane University School of Medicine, New Orleans, LA, 1968; interned Grady Hospital, Atlanta, GA, one year; anesthesiology residency, Ochsner Clinic, New Orleans, 1969-70 and 1972-75; elected by Central Medical Society.

FENTER, THOMAS C., Jackson. Born Brookhaven, MS, June 21, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned Baylor University Hospital, Dallas, TX, one year; general surgery residency, same, 1971-72; urology residency, University Medical Center, Jackson, MS, 1972-75; elected by Central Medical Society.

HARPER, GERALD H., Laurel. Born Laurel, MS, Jan. 24, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned University Medical Center, Jackson, MS, one year; obgyn residency, same, 1974-77; elected by South Mississippi Medical Society.

HUTCHINS, KELLY E., Laurel. Born Big Creek, MS, July 21, 1934; M.D., University of Alabama School of Medicine, Birmingham, 1974; interned University of Alabama Hospital, Birmingham, one year; pathology residency, same, 1974-76; elected by South Mississippi Medical Society.

PUROHIT, SURENDRA K., Tylertown. Born Nagpur, India, Nov. 9, 1942; M.D., Medical College and Hospital, Nagpur University, Nagpur, Maharashtra, India, 1968; interned Worcester City Hospital, Worcester, MA, one year, 1970-71; surgery residency, same, 1971-75; elected by South Central Medical Society.

LACKEY, VAN L., Jackson. Born Jackson, MS, Sept. 5, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned, same, one year; medicine residency, same, 1973-75; hematology and oncology residency, same, 1975-77; elected by Central Medical Society.

ROBINSON, JOSEPH H., Jackson. Born Alexandria, LA, Nov. 14, 1941; M.D., Louisiana State University School of Medicine, New Orleans, 1967; interned Confederate Memorial Hospital, Shreveport, LA, one year; dermatology residency, Charity and V. A. Hospitals, New Orleans, LA, 1971-74; elected by Central Medical Society.

SEITH, WILLIAM F., JR., Biloxi. Born Monroe, LA, Sept. 15, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned Keesler AFB Hospital, Biloxi, MS, one year; medicine residency, same, 1970-73; neurology residency, University of Florida, Gainesville, FL, 1973-76; elected by Coast Counties Medical Society.

SHEFFIELD, THOMAS E., Columbus. Born Moorehead, MS, Nov. 19, 1945; M.D., University of Mississipi School of Medicine, Jackson, 1971; interned and medicine residency, University of Mississippi Medical Center, Jackson, 1971-74; elected by Prairie Medical Society.

STANCILL, HUGH W., III, Laurel. Born Greenwood, MS, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned Duke University Medical Center, Durham, NC, one year; obgyn residency, University Medical Center, Jackson, MS, 1974-77; elected by South Mississippi Medical Society.

SUARES, ROBERT NEAL, Greenville. Born Spartanburg, SC, July 17, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned Mississippi Baptist Hospital, Jackson, MS, one year; ophthalmology residency, University Medical Center, Jackson, MS, 1972-75; elected by Delta Medical Society.

POSTGRADUATE CALENDAR

Feb. 25-26, 1978

MISSISSIPPI ACADEMY OF FAMILY PHYSICIANS MEETING

Holiday Inn Medical Center and University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Family Medicine, the University Medical Center Division of Continuing Health Professional Education and the Mississippi Academy of Family Physicians.

Coordinators: Wilfred R. Gillis, M.D., professor of family medicine and chairman of the department, University of Mississippi School of Medicine; and Ralph L. Brock, M.D., clinical instructor in family medicine, University of Mississippi School of Medicine.

This one and one-half day seminar is the first semi-annual scientific session for Mississippi Academy of Family Physicians members. New advances and techniques for the practicing family physician will be discussed. Fee: $30.00. Credit: Category I, AMA; AAFP applied for.

Mar. 9-11, 1978
SURGICAL FORUM V
Holiday Inn Downtown, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Surgery and the University Medical Center Division of Continuing Health Professional Education.

Coordinators: James D. Hardy, M.D., professor of surgery and chairman of the department, University of Mississippi School of Medicine; and William O. Barnett, M.D., clinical professor of surgery, University of Mississippi School of Medicine.

Surgical management of obesity, management of hyperthyroidism, splenectomy and management of Hirschsprung's Disease will be main discussion topics. An international guest faculty will lead this postgraduate seminar. Attendance is by invitation and advance registration is required. Fee: $150.00. Credit: 17 contact hours, 1.7 CEU, Category I, AMA.

Mar. 15-17, 1978
NEWBORN VENTILATION
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics Division of Newborn Medicine and the University Medical Center Division of Continuing Health Professional Education.

Coordinator: Gwendolyn Bussa, M.N., assistant professor of nursing, University of Mississippi School of Nursing and instructor in obstetrics-gynecology, University of Mississippi School of Medicine.

This two-day course will include lectures on the anatomy and physiology of ventilation, indications for ventilation and the practical problems of ventilation. Initiation and maintenance of the newborn on artificial ventilation will be emphasized. Fee: $75.00. Credit: 14 contact hours, 1.4 CEU, Category I, AMA; AAFP.

Mar. 20-31, 1978
NEWBORN CARE FOR PHYSICIAN AND NURSE TEAMS
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics Division of Newborn Medicine and the University Medical Center Division of Continuing Health Professional Education.

Coordinator: Gwendolyn Bussa, M.N., assistant professor of nursing, University of Mississippi School of Nursing and instructor in obstetrics-gynecology, University of Mississippi School of Medicine.

This two-week course will help participants learn more about the team approach to neonatal care. Enrollment is limited to one team of two nurses and one physician from the same hospital. There will be a fee. Credit: Category I, AMA; AAFP applied for.

Mar. 30-April 1, 1978
GASTROENTEROLOGY UPDATE
Ramada Inn Coliseum, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Medicine Division of Digestive Diseases and the University Medical Center Division of Continuing Health Professional Education.

Coordinator: James Achord, M.D., professor of medicine and director of the division of digestive diseases, University of Mississippi School of Medicine.

The three-day course on digestive diseases will be presented by guest faculty. The course is designed to bring the practicing physician up-to-date on new advances and concepts in gastroenterology. Attendance is limited and by invitation. Advance registration is required. Fee: $150.00. Credit: 18 contact hours, 1.8 CEU, Category I, AMA; AAFP.

All continuing education correspondence should be addressed to: Continuing Health Professional Education, University Medical Center, 2500 North State Street, Jackson, MS 39216.

FUTURE CALENDAR

April 6-7, 1978
SOUTHEASTERN REGIONAL FACULTY DEVELOPMENT WORKSHOP
Holiday Inn Medical Center, Jackson

April 13-14, 1978
May 25-26, 1978
NEWBORN RESUSCITATION
University Medical Center, Jackson

April 27-28, 1978
AGING
University Medical Center, Jackson

May 5-6, 1978
THE INSULIN DEPENDENT DIABETIC
Holiday Inn Medical Center, Jackson

May 11-12, 1978
NEWBORN NUTRITION
University Medical Center, Jackson

SBH Reports on Meningococcal Disease in Mississippi

Four fatal cases of meningococcal disease were reported in Mississippi since April 1977 in young adults. These deaths along with reports of somewhat increased activity of serogroup B activity in southern Louisiana prompted a review of the cases reported to the State Board of Health in Mississippi. From January through November 1977 there were 35 reported cases of meningococcal disease of which 31 were documented by blood or spinal fluid culture or by counter-immunoelectrophoresis of spinal fluid identifying the polysaccharide antigen. Four were felt to be clinical cases by the reporting physician despite negative culture results. Characteristics of the fatal cases are as follows:

Age	*Race*	*Sex*	*Residence*	*Sero-group*	*Onset*
19	W	M	Greenville, Washington Co.	C	4-16-76
20	B	M	Hazlehurst, Copiah Co.	B	4-29-76
21	W	F	Winona, Montgomery Co.	C	7-26-77
19	W	F	Hattiesburg, Forrest Co.	C	9-15-77

Of the 3 documented cases 11 (42.9 percent) were not serogrouped. Of the 20 serogrouped, 9 (45 percent) were B, 8 (40 percent) were C and 3 (15 percent) were group Y, which compares well to the 46 percent, 30 percent, and 17 percent for the respective serogroups identified in the 1974 year by Center for Disease Control. Of the 35 total cases 3 were reported as meningococcemia alone and the remainder as meningitis with or without meningococcemia. The case fatality rate is 11.4 percent (or 12.9 percent if culture negative cases are excluded).

The statewide rate is 1.6 cases per 100,000 population per year assuming zero cases for December (a reasonable estimate of two cases in December would give a rate of 1.7) which is minimally increased over the rate of 0.6 for the United States and the state in 1974. The distribution of cases over the year shows the expected peak of activity in the spring. The high attack rate in 1966 was seen nationwide and was predominantly serogroup B.

Racial and sexual breakdown reveals 16 blacks (8 male and 8 female) and 18 whites (4 males and 14 females) with case rates of 1.9 and 1.3 for blacks and white respectively. Almost two thirds of the cases were females even though males are reportedly more commonly affected.

The number of cases by age is 2 cases for less than 1 year of age, 12 cases for 1-4 years, 12 cases for 5-19, and 9 cases for $>$ 20 years.

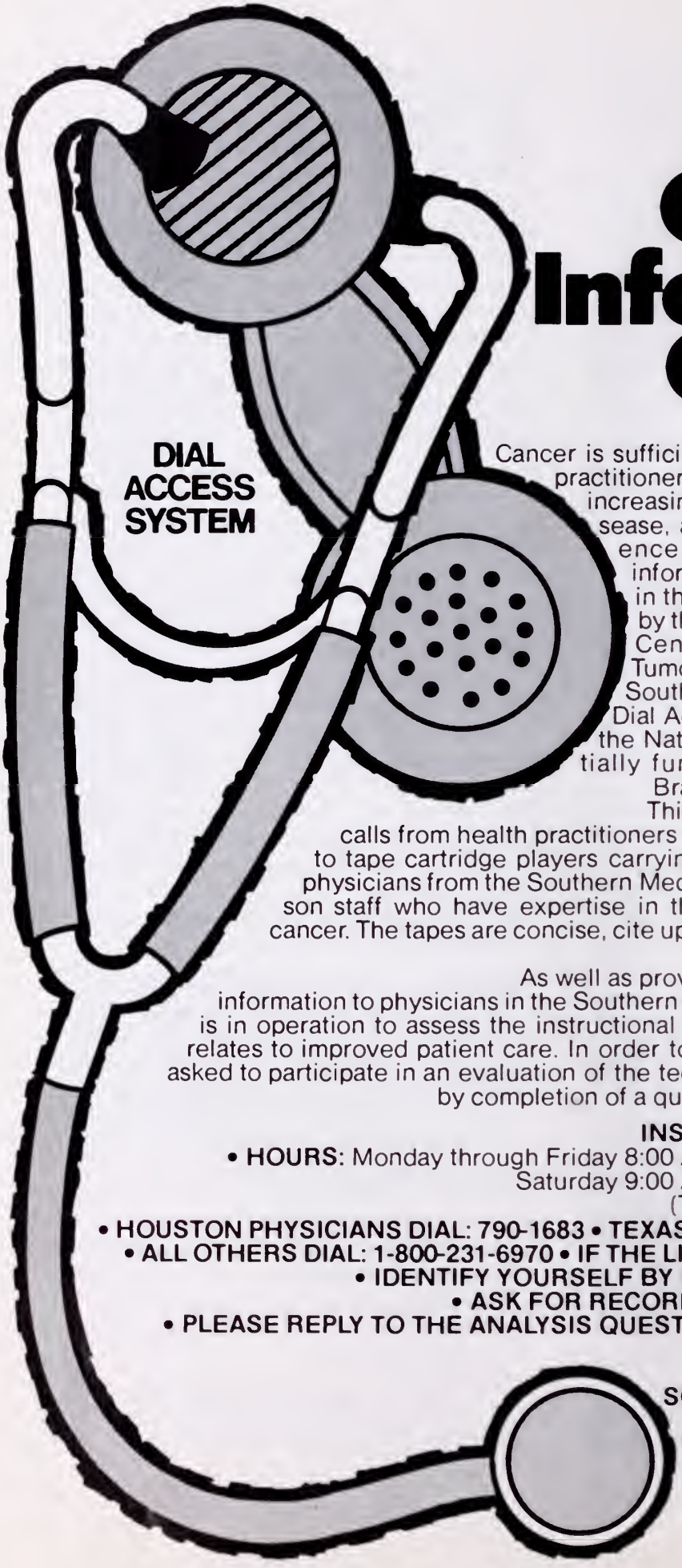
Only 17 of the 82 counties reported a case of meningococcal disease in 1977 and 11 of these had only a single case. The case rates were 2.4 and 2.1 in the lowest and middle group of counties and only 0.6 in the northern group which is in agreement with the Louisiana experience. Forrest County reported the greatest number of cases (8) and the highest county case rate (13.8) although there is only one household with two cases and both siblings became ill the same day (co-primary cases). The serogroups in Forrest County are 2 of group B, 3 of group C, and 3 non-serogrouped. If the other three cases were serogrouped, an impression about whether this represents epidemic activity of any one group or a general increase of all groups could be made. This distinction is of possible importance since vaccines for group A or C could be used in select populations in the event of localized epidemic activity.

In summary, Mississippi has had an "average" year for meningococcal disease and in contrast to the experience in neighboring states, reported cases do not suggest an excess of serogroup B isolates, however, the fact that 11 cases were not tested may have obscured that observation. The noticeably higher case rate in the Southern regions is noted however as well as a focus of activity in Forrest County that is not yet explained.

The Mississippi State Board of Health makes the following recommendations:

1. Continue prompt immediate reporting of meningococcal cases to county health departments.
2. Obtaining and reporting the serogroup from cultures or counter-immuno electrophoresis of spinal fluid is stressed to assist in epidemiologic assessment a well as to provide the opportunity to use group specific vaccine (A or C only) in contacts or select high risk populations in the event of localized epidemic activity.
3. Continue prompt prophylactic therapy of household or nursery contacts with rifampin* since 33 percent of the secondary cases occur within 4 days of the index case's hospitalization.
4. Culturing of household contacts is of no value and to be avoided.

* Adults—600 mg P.O. every 12 hours for 4 doses; children—10 mg/kg (not to exceed 600 mg) P.O. every 12 hours for 4 doses; infants (3-12 months)—5 mg/kg P.O. every 12 hours for 4 doses.



SMA Cancer Information Center

Cancer is sufficiently prevalent that it touches every practitioner directly or indirectly. To facilitate the increasingly complex management of this disease, an easily accessible source of reference data is needed. This much-needed information is being supplied to physicians in the Southern Medical Association area by the University of Texas System Cancer Center, M.D. Anderson Hospital and Tumor Institute, in cooperation with the Southern Medical Association. Known as Dial Access, this system is an outgrowth of the National Cancer Act of 1971 and is partially funded through the Cancer Control Branch of the National Cancer Institute.

This system provides toll-free telephone calls from health practitioners in all 17 states through 5 WATS lines to tape cartridge players carrying some 350 narrations authored by physicians from the Southern Medical Association and the M.D. Anderson staff who have expertise in the management of various types of cancer. The tapes are concise, cite up to three references, and have author identification.

As well as providing cancer management reference information to physicians in the Southern Medical Association area, the project is in operation to assess the instructional value of this and similar systems as relates to improved patient care. In order to accomplish this last, callers will be asked to participate in an evaluation of the technique and information transmitted, by completion of a questionnaire mailed to first-time users.

INSTRUCTIONS FOR USE OF SYSTEM

• **HOURS:** Monday through Friday 8:00 AM—1:00 PM Central Standard Time
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For Free Catalog, Write:
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2601 Highland Avenue
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The 110th Annual Session of MSMA Is Scheduled for May 1-4 at Jackson

Plans are being finalized for the 110th Annual Session of the Mississippi State Medical Association, set for May 1-4, 1978, at the Coliseum Ramada Inn in Jackson.

The 13 scientific sections of the Council on Scientific Assembly are planning informative and stimulating programs, according to council chairman, Dr. J. Elmer Nix of Jackson.



Dr. Nix

Additional program offerings include a Sunday afternoon April 30, seminar on the National Health Planning and Resources Development Act and an array of scientific and technical exhibits.

Some 15 medical specialty and related organizations plan to host concurrent meetings, social and scientific, during the MSMA annual session, Dr. Nix said.

Business of the association will be conducted in the House of Delegates meetings on May 1 and May 4 and the reference committee hearings on May 1. A special feature will be an address by the president of the American Medical Association.

The annual meeting of the Mississippi Foundation for Medical Care, Inc., will also take place on Monday afternoon, May 1.

The University of Mississippi, Tulane and the University of Tennessee medical alumni associations are planning social events for Monday evening, May 1, at the Coliseum Ramada Inn.

Also meeting in conjunction with the MSMA convention will be the 54th annual session of the Mississippi State Medical Association Auxiliary. Mrs. William Hilbun of Tupelo is president of the auxiliary and Mrs. G. S. Rowlett of Vicksburg is president-elect.

The association will host an MSMA Fellowship Party for members and exhibitors on Wednesday evening, May 3. Tickets will be available at the MSMA Registration Desk.

For the second year there will be a tennis tournament for MSMA members and spouses. Chairman of this event will be Dr. Henry Tyler of Jackson.

For more information regarding the convention, write Council on Scientific Assembly, MSMA, P. O. Box 5229, Jackson, MS 39216. The complete annual session program will be published in the April issue of the JOURNAL MSMA.

JOIN

MPAC

TODAY

MSMA and MHA Seek Cost Containment

MSMA and the Mississippi Hospital Association have joined together to formulate a voluntary cost containment program for hospital services in the state.

The program is an outgrowth of a national steering committee formed by the AMA, AHA and Federation of American Hospitals in December in response to a challenge from Congress for a voluntary alternative to the Carter Administration's proposed Hospital Cost Containment Act. Other members of the national steering committee are from the Health Insurance Association of America, the Health Industry Manufacturers Association, the Blue Cross Association, the U. S. Chamber of Commerce and consumer consultant, Virginia Knauer.

Following recommendations of the national steering committee, each state will have a similar steering committee which will receive and review monthly data from hospitals on their cost efficiency progress. A "very realistic goal" of a 2 per cent annual reduction in the rate of increase in hospital costs over the next two years was set forth by AHA president, J. A. McMahon.

SBH Controversy Erupts Again

The January meeting of the Mississippi State Board of Health erupted into controversy over who were legally seated members when new appointees of Governor Cliff Finch appeared at the meeting.

The new appointees, who were named shortly before the meeting by the governor, were Drs. John W. Murphy, Jackson, John R. Lovelace, Batesville, Gilbert R. Mason, Biloxi, and Doris Mitchell, R.N., of Cleveland.

The meeting erupted when Board Member John Egger of Drew asked "who were the legal members of the Board?" Board president Moncure Dabney of Crystal Springs responded after much parliamentary debate by reading an opinion from the Attorney General's Office which in effect stated that appointments made by the governor must be confirmed by the Senate and lack of confirmation was an annulment of the appointment.

The names of Drs. Lovelace, Howard Clark of Morton, Gilbert R. Mason of Biloxi and William A. Middleton of Winona had been submitted to the Senate last year and the Senate refused to confirm them. Dr. Lovelace had subsequently resigned from the Board and Dr. Mason's appointment was for a term expiring Jan. 1, 1978.

The controversy over gubernatorial appointments to the Mississippi State Board of Health began in May 1976 when Governor Finch appointed Drs. Clark and Middleton to the Board neither of which had been nominated by the Mississippi State Medical Association in accordance with state statutes. Subsequently, the governor said the statute meant any medical association and submitted Drs. Clark's, Middleton's and Dr. Mason's, a black physician, names to the Senate for confirmation during the 1977 Mississippi Legislature as appointees from nominations made by the Mississippi Medical and Surgical Association, a predominantly black organization with some 40 physician members.

After the appointees failed to gain confirmation by the Senate, lawsuits, which are still pending, were filed in Federal and State courts.

Emergency Medical Care Unit Opens at Capitol

The MSMA Emergency Medical Care Unit in the Capitol Building at Jackson opened Jan. 3, 1978, for the fourteenth consecutive year of service during the 1978 Regular Session of the Legislature.

The association's public service project is again staffed by Mavis Barlow, R.N., of Florence. Physician's services are provided by volunteer Doctors of the Day.

Response by the MSMA membership to DOD assignment requests has been excellent, according to Dr. Charles R. Jenkins of Laurel, chairman of the Council on Legislation.

Legislative leaders have praised the service which costs the state nothing. Physicians contribute their services, and association funds are used to defray direct expenses. Some pharmaceutical firms donate supplies and drugs, and the state furnishes the unit space, a telephone, utilities and janitorial services.

Mrs. Barlow said the unit's practice is brisk. Conditions seen in previous years ranged from the common cold to heart attacks. The EMCU serves the legislators and Capitol employees.

"A Shot in the Arm" Is Needed

A shot in the arm is what more Mississippi children need based on immunization statistics compiled by the Mississippi State Board of Health.

A random sample by the SBH shows that substantial numbers of Mississippians under two years of age have not completed their immunization schedule.

According to the survey, only 46 per cent had received recommended levels of diphtheria, whooping cough and tetanus vaccinations, 58 per cent recommended doses of polio vaccine and 71 per cent inoculations for measles and rubella.

The impact of the low inoculation levels may be reflected in recent statistics on the incidence of measles in Mississippi during 1976 and 1977. In 1976 a total of 18 cases of measles were reported. In 1977 some 100 cases of measles were reported.

Mississippi's statistics on immunization levels are reflective of the national scene and last year the federal government in cooperation with numerous voluntary health organizations announced a two year "Immunization Initiative Program" to inoculate an estimated 20 million children. The Mississippi State Medical Association Auxiliary has begun plans to participate in the program along with other interested organizations.

CLASSIFIED

GENERAL PRACTITIONER needed to organize, staff, equip and operate Satellite clinic office in affiliation with 144 bed general acute hospital in Biloxi, MS. Physician must have a minimum of 10 years private practice experience including general medicine, general surgery, obstetrics, and routine ENT surgery. Must have completed 1 year approved internship and 3 years approved residency. Hospital will provide loan to assist in first year of practice. Reply to: MS. State Employment Service, 102 W. Washington St., Biloxi, MS 39530.

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Index to Advertisers

Air Force ... 8
Burroughs Wellcome Co. ... 6C
Canton Exchange Bank ... 16
Doctors Needed ... 6
Health Resources Corp. ... 19
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Warren-Teed Pharm., Inc. ... 17
Thomas Yates and Co. ... 3

IN CONCLUSION

A Consumer Product Safety Commission study estimates that 375,000 people will be injured in skateboard accidents in 1977, compared to 370,000 in all nonprofessional football games in this country. This number represents approximately double last year's skateboard injury figure of 188,000 In addition, a report based on the study notes that only a very small percentage of the injuries will result from defects in the skateboard. Instead, they will be caused by inexperience or environmental hazards such as potholes.

A preliminary study to determine the feasibility and desirability of offering a prepaid hospital and non-hospital drug abuse treatment benefit nationwide will be undertaken by Blue Cross Association this year. Currently, only one-half of one per cent of the total cost of treatment is covered by private insurance and health care prepayment programs. Federal, state and municipal government funding supports most of the drug abuse treatment in the U.S. Blue Cross study is funded by a grant from the National Institute on Drug Abuse.

A study committee has urged overhaul of New Jersey's controversial no-fault automobile insurance program to limit "pain and suffering" litigation. The committee's report recommends replacing the $200 limit that insurance companies have to pay for their own policyholders' medical bills, regardless of who is at fault. The driver now has to sue the other party to recover damages that exceed the $200 limit. The study committee is calling for alternatives to the specific dollar figure. Problems with "no fault" insurance continue to occur in all states enacting such legislation.

American College of Obstetricians and Gynecologists endorsed concept of full equal rights for women. Warren Pearse, M.D., ACOG executive director, said, "As the largest national medical organization concerned with the health care of women, we wish to publicly express our support for equal rights....Since ACOG is not a political organization and recognizes that its membership encompasses a wide range of views, we cannot insist that our member physicians become involved in political action, but we do encourage them to support specific ERA legislation at state level."

Medical Economics states that a report entitled "Crisis Ahead for Doctor-Owned Malpractice Carriers" suggested inaccurately that a recent IRS ruling might make premiums paid to physician-owned insurance companies nondeductible. Faulty interpretation of the ruling was initially confirmed by IRS and after publication, IRS stated ruling was not applicable to most doctor-owned carriers. Ruling is directed at offshore firms established by large U.S. companies to provide coverage to parent company and subsidiaries.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

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Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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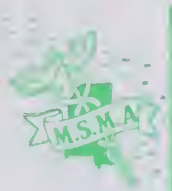
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CONTENTS

ORIGINAL SCIENTIFIC PAPERS

Clinical Diagnosis of Pleural Disease **41** JAMES E. GRIFFITH, M.D., and GUY D. CAMPBELL, M.D., Jackson, MS

Pain in Malignancy: Cordotomy **46** ROBERT A. SANFORD, M.D., and BERNARD S. PATRICK, M.D., Jackson, MS

SPECIAL ARTICLE

Radiologic Seminar CLXXIX: The Case for the Clean Colon **50** R. B. ELLISON, M.D., Jackson, MS

EDITORIAL

The LeVeen Peritoneal-Jugular Shunt **53** GEORGE H. MARTIN, M.D., Vicksburg, MS

THIS MONTH

The President Speaking **52** Public Ambivalent on Health Care

Medical Organization **57** MSMA's Big 110th Annual Session Approaches

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Secretary Califano Rides Again

HEW Secretary Califano, who left a $450,000 a year law practice and stirred the AMA House of Delegates shortly after assuming office with remarks that "Doctors made too much money," has apparently now decided to take on the tobacco industry and its multitude of loyal followers.

Califano, a reformed cigarette smoker, announced a new government sponsored public awareness program against smoking with all the fanfare appropriate to the announcement of the end of World War II or America's first space launching.

Califano asked the U. S. Treasury to consider an increase in excise tax on cigarettes. The Federal Trade Commission was urged to strengthen warnings on cigarette packages. Health insurers were urged to charge smokers higher premiums. And, the Food and Drug Administration after prodding from Califano immediately revised labeling of oral contraceptives to advise women who used birth control pills not to smoke.

Califano's program drew expected fire from the tobacco industry. The president of one large cigarette company called the Secretary an "ass" and indicated that he was a compulsive meddler.

Tobacco farmers seeing their jobs and livelihoods going under a government sponsored onslaught immediately protested to their states' congressional delegations. The congressmen in turn attacked Califano and indicated that HEW's appropriations would be in trouble.

The White House, however, whose present occupant is a reformer himself of some note, might have displayed the most negative view of Secretary Califano's anti-smoking drive. According to a by-line story in the Baltimore *Morning Sun:* "Aides to President Carter fear that the campaign will be ineffective and that it will be interpreted as excessive government interference in Americans' private lives."

Family Medicine Review Is Set

The ninth family medicine review has been scheduled for: Session I: June 25-30, 1978, Session II: August 13-18, 1978, and Session III: December 10-15, 1978, at the Hyatt Regency, Lexington, KY.

Registration fee is $295.00 and 50 hours of AAFP credit and Category I, AMA Physician's Recognition Award Credit, has been approved.

For more information contact: Frank R. Lemon, M.D., University of Kentucky Medical Center, Continuing Education, College of Medicine, Lexington, KY 40506.

MARCH 31-APRIL 4, 1978

41st Annual

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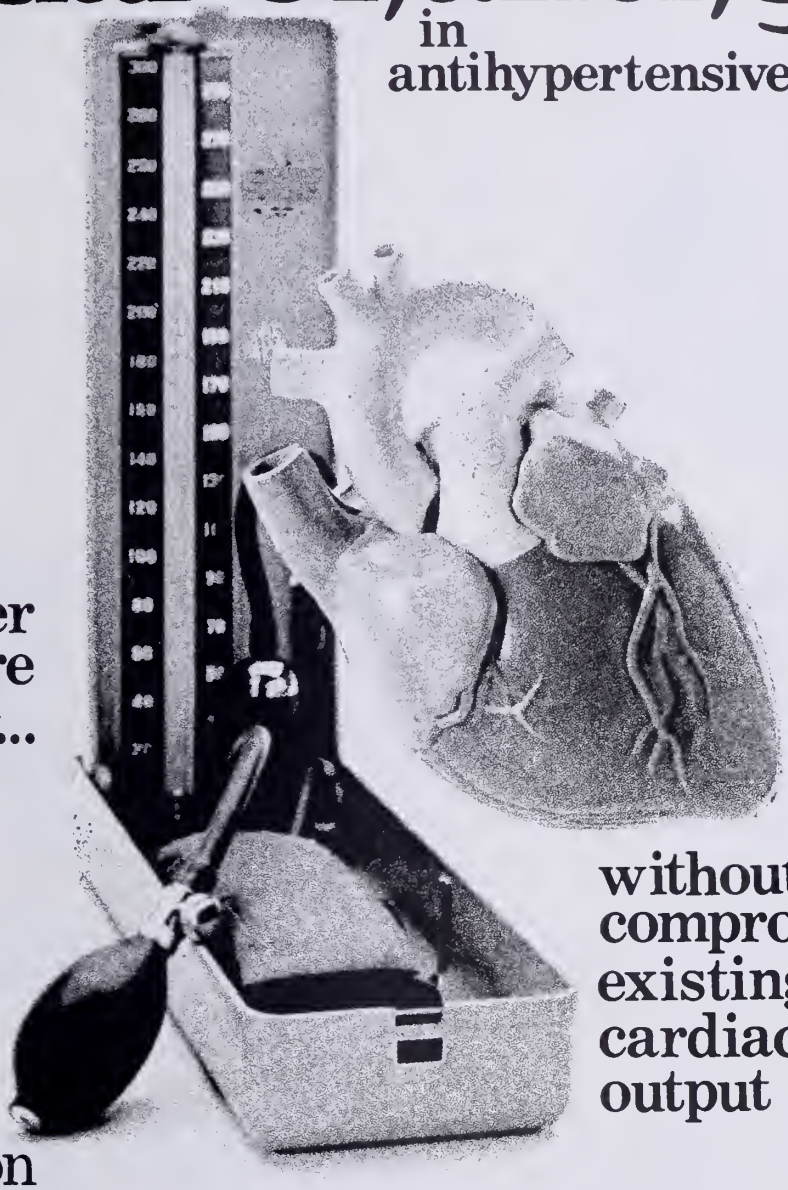
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A Dual Challenge

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to lower
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without
compromising
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cardiac
output

in hypertension

TABLETS: 250 mg, 500 mg, and 125 mg

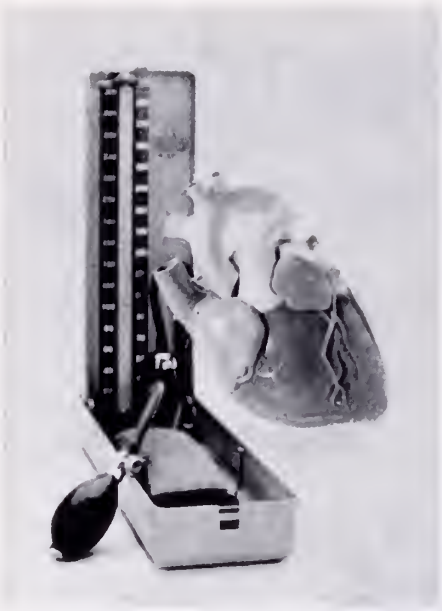
ALDOMET® (METHYLDOPA | MSD)

helps lower blood pressure effectively...
usually with no direct effect on
cardiac function–cardiac output
is usually maintained

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders.
It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

MSD
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SHARP &
DOHME



in hypertension

ALDOMET®

(METHYLDOPA|MSD)

helps lower blood pressure effectively... usually with no direct effect on cardiac function– cardiac output is usually maintained

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, occasionally with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Pregnancy and Nursing: Use of any drug in women who are or may become pregnant or intend to nurse requires that anticipated benefits be weighed against possible risks; possibility of fetal injury or injury to a nursing infant cannot be excluded. Methyldopa crosses the placental barrier, appears in cord blood, and appears in breast milk.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: urinary uric acid by the phosphotungstate method, serum creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient, dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements, psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia. Positive tests for antinuclear antibody, LE cells, and rheumatoid factor.

Allergic: Drug-related fever, lupus-like syndrome, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third months of therapy; increased dosage or adding a diuretic frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100. Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000. Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 500.

For more detailed information, consult your MSD representative or see full prescribing information.
Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

J6AM07R1(709)

MSD MERCK SHARP & DOHME

NEWSLETTER

March 1978

Dear Doctor:

The Mississippi Legislature has joined a growing number of state legislatures that have come under attack from the "Laetrile Lobby" and not crumbled. A House bill to legalize the substance died on the calendar and in the Senate after an emotional public hearing. Senators Perrin Purvis of Tupelo, Jim Molpus of Clarksdale, and Jim Noblin of Jackson voted against reporting the bill out of their committee thus sealing the fate of the bill.

> As Journal MSMA went to press, the Mississippi Legislature was close to approving the first increase in Medicaid payments to physicians since the program began in 1970. Bills were on both the Senate and House calendars to increase payments to the BS F-450 Schedule. MSMA has sought increase.

The Mississippi Medical Fraternal and Educational Society has issued over 250 policies since it formally began operation. Some 800 Mississippi physicians have now paid their dues to the society. MMFES dues are $1,000 for new physicians and $1,500 for physicians who did not join during last year's membership solicitation campaign.

MSMA members are reminded once again that the association will accumulate their continuing medical education hours and annually report their total hours back to them. All that is needed is for you to forward to the Jackson office the title of the CME activity, its sponsor's name, dates of attendance and number of hours received per meeting or course.

Medical students will get a tax break with the passage of a bill to free their federal scholarship stipends from federal income taxation. The exemption had been urged by the AMA. As adopted by the U.S. Congress, the bill provides for a two-year exemption. The AMA-proposed legislation would have made the tax exclusion a permanent one.

Missouri is activating a physician-sponsored captive insurance company and the Texas Medical Association is retaining an insurance consulting firm to study the feasibility of establishing a captive in that state. There are now 17 captive companies in operation. A captive is a medical society-sponsored company. Captives now insure some 75,000 physicians.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

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Mississippi Council of Coca-Cola Bottlers

Health Guidelines Are Reissued

The federal government has released a second version of the controversial health planning guidelines, saying the revised rules contain "enough flexibility to be fair, and are tough enough to be effective."

When the original guidelines were published last fall in the *Federal Register,* the Department of Health, Education and Welfare received more than 55,000 mostly critical comments, stating the belief that the rules were unfair to small, rural hospitals. MSMA was among the protestors.

The response evidently took the agency by surprise and the guidelines were withdrawn to be revised in such form as to be more acceptable. The revised rules will be open to comment until March 6 at which time the final regulations will be published.

HEW Secretary Joseph Califano emphasized that the guidelines are to serve as national standards for local Health System Agencies and state health planning bodies, which must make the final decisions. In Mississippi that will be the Mississippi Health Systems Agency, Inc. and the Governor's State Health Planning and Development Agency.

Califano said HEW's ability to enforce the guidelines is limited to two areas. One, if a local hospital proceeded with capital expenditures in violation of a state-adopted plan, HEW could withhold funds that are provided for reimbursement of depreciation costs. Two, HEW does have the power to "decertify" local HSAs that completely disregard the guidelines. However, Califano stressed that planning authorities rest in local hands.

The revised guidelines propose these major standards:

- A maximum of four hospital beds per 1,000 people.
- An average annual occupancy rate of at least 80 per cent for hospitals in a Health Service Area.
- At least a 75 per cent average occupancy rate and at least 1,500 births annually for hospitals that provide care for complicated obstetrical problems.
- No more than four neonatal intensive and intermediate care beds per 1,000 live births.
- A minimum of 20 beds for pediatric units in urban areas.
- Average annual occupancy rate ranging from 65 per cent to 75 per cent for pediatric units, based on their size.

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– it isn't just for simple cutaneous candidiasis*

– it isn't just for simple bacterial infection*



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* **INDICATIONS:** Based on a review of this preparation by the National Academy of Sciences – National Research Council and/or other information, FDA has classified the indications as follows. **Possibly effective:** In cutaneous candidiasis; superficial bacterial infections; the following conditions when complicated by candidal and/or bacterial infection: atopic, eczematoid, stasis, nummular, contact, or seborrheic dermatitis, neurodermatitis, and dermatitis venenata; infantile eczema; lichen simplex chronicus; and pruritus ani and pruritus vulvae.

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Viral diseases of the skin (such as vaccinia and varicella); fungal lesions of the skin except candidiasis; history of hypersensitivity to any product component. Not intended for ophthalmic use; should not be applied in the external auditory canal of patients with perforated eardrums; should not be used when circulation is markedly impaired.

WARNINGS: Because of the potential hazard of nephrotoxicity and ototoxicity, prolonged use or use of large amounts of this product should be avoided in the treatment of skin infections following extensive burns, trophic ulceration, and other conditions where absorption of neomycin is possible.

Usage in Pregnancy: Although topical steroids have not been reported to have an adverse effect on the fetus, the safety of topical steroids during pregnancy has not been absolutely established; therefore, do not use extensively on pregnant patients, in large amounts, or for prolonged periods.

PRECAUTIONS: Watch constantly for overgrowth of nonsusceptible organisms (including fungi other than candida). Should superinfection due to nonsusceptible organisms occur, administer suitable concomitant antimicrobial therapy; if favorable response is not prompt, discontinue the preparation until adequate control by other antiinfectives is effected. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid; suitable precautions should be taken. If irritation develops, discontinue the product and institute appropriate therapy.

ADVERSE REACTIONS: Sensitivity reactions to topical use of gramicidin are rare. Hypersensitivity to nystatin is extremely uncommon. Hypersensitivity to neomycin has been reported and articles in the current medical literature indicate an increase in its prevalence.

The following local adverse reactions have been reported with topical corticosteroids either with or without occlusive dressings: burning sensations, itching, irritation, dryness, folliculitis, secondary infection, skin atrophy, striae, miliaria, hypertrichosis, acneform eruptions, maceration of the skin, and hypopigmentation. Contact sensitivity to a particular dressing material or adhesive may occur occasionally. Ototoxicity and nephrotoxicity have been reported.

For full prescribing information, consult package insert.

HOW SUPPLIED: Available in 15, 30, and 60 g tubes. It is also available in jars of 120 g (4 oz.) for hospital or institutional use only.

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- At least 200 open heart procedures annually in any institution in which open heart surgery is performed for adults, and at least 100 heart operations annually in any institution in which pediatric open heart surgery is performed.
- At least 300 cardiac catheterizations annually in any adult catheterization unit, and at least 150 cardiac catheterization units annually in any pedi-tric catheterization unit.
- A service area with a population of at least 150,-000 people, or treatment of at lcast 300 cancer cases annually, for megavoltage radiation therapy units.
- At least 2,500 procedures per year for each computed tomography scanner.
- Plans consistent with already established HEW standards and procedures for suppliers of end-stage renal disease services.

The revised guidelines if literally enforced in Mississippi would still close a large number of Mississippi hospitals and hospital ob services.

Fed Regs Increase Hospital Costs

A recently completed study verifies that government regulations are running up the cost of hospital services.

The study, which can be applied in all states, was conducted by the Michigan Hospital Association and used an independent accounting system developed by Arthur Young and Company.

Results of the study indicate that six federal regulations alone are costing patients $24 for an average hospital stay.

The six areas studied were: utilization review, physical plant codes, personnel management, the medical arbitration program, certificate of need, and Medicare-Medicaid reimbursement mechanics.

Carter Proposes Lean Health Budget

The first health budget fully developed by the Carter administration targets spending increases to a few population groups while most other health efforts hold the line or even fall short of keeping pace with inflation.

The newly released $181.2 billion fiscal 1979 Department of Health, Education and Welfare budget expands Medicaid to cover all low-income pregnant women, adds a million eligibles to the Child Health Assessment Program (CHAP) legislation introduced last year, ups spending to immunize the nation's schoolchildren, and adds $142 million in health and family planning services for teenagers with emphasis on avoiding unwanted pregnancies.

DOCTORS NEEDED

To perform consultative examinations for Disability Determination Services (a State Agency).

These examinations can be done in your office and will be used to determine if disability applicants meet the definition of disability under the Social Security Act.

Specialties needed:

Internists, Neurosurgeons, Neurologists, Psychiatrists, Orthopedists, Ophthalmologists, Pediatricians, and Otolaryngologists.

Also needed:

Family Practitioners and General Practitioners who are equipped to perform comprehensive medical examinations.

Payment is usually on a customary fee basis for both consultation and laboratory fees.

For more information, call or write:

Ed Adams
Professional Relations Officer
Disability Determination Services
P. O. Box 1271
Jackson, MS 39205

Phone: 1-800-222-8325 (toll free)
If in Jackson: 969-6811

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Indianapolis, Indiana 46206

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DATELINE

Mississippi Newborn Fact Sheet Issued

Jackson, MS - The Mississippi chapter of the American Academy of Pediatrics has released a newborn fact sheet for the state which estimates that the anticipated live births in Mississippi per year are around 40,000. The need for infant intensive care is about 4,000 a year. At present, Mississippi is capable for adequately caring for 1,000 intensive care babies per year with 13 hospitals around the state having ventilatory capacity and 100-105 NICU beds.

Doctors Are Common Hepatitis Carriers

Chicago, IL - Federal investigators say one in three surgeons and pathologists have been infected with hepatitis at least once and doctors are the most common carriers of the virus. Doctors contract the liver disease five times more often than other persons, making hepatitis a significant occupational hazard, according to the Center for Disease Control. Main source of infection was found to be exposure to blood or blood products which may harbor virus.

Heart Association Is Against Smoking

Miami, FL - Using no-nonsense language, the American Heart Association has called for further restriction of cigaret advertising and urged health professionals to "set a personal example by not smoking cigarets themselves, or allowing it on their premises." A committee of AHA reported to the annual meeting here that cigaret smoking is responsible for an estimated 325,000 premature deaths each year. AHA advocates making sale of cigarets to children a legal offense.

Census Will Include Physicians

Washington, DC - Physicians will be included in census in Service Industries Section for first time since 1905. Physicians are being asked to disclose their gross receipts, capital expenditure, gross value of fixed assets, and other financial matters. One hundred thousand physicians will receive census forms. Any data given is for statistical purposes only. Should you receive a form, full completion is mandatory and a fine of $500 is the penalty for noncompliance.

Selenium in Yeast Tablets Is Dangerous

Chicago, IL - Yeast tablets containing selenium, on sale at some health food stores, are potentially dangerous and should be avoided, according to the AMA. Selenium is a trace element found in nature and in man and in normal amounts is harmless and may be useful. Much of the selenium consumed is excreted in urine. But in overdose, it can be very harmful and even fatal to animals and is likely harmful to humans. It can cause blindness, paralysis and death.

Canadian Doctors Criticize NHI

A national health program that pays physicians' fees as well as hospital bills is a mixed blessing, say Canadian physicians after more than a decade of experience with government medicine.

The American Medical Association polled Canadian physicians to learn what they think of a national health program that is similar in many respects to plans proposed for the United States.

Canadian physicians declare that in some ways the national health program is good for patients, removing fears about big medical bills and making medical care accessible to everyone. The dark side of the coin, however, is that the quality of medical care declines as it becomes more assembly line and impersonal in nature, the Canadian doctors say.

It is not so good for the doctor, locking him into a paper-heavy, bureaucratic system, eroding his professional freedom, and forcing him to see increasing numbers of patients just to stay even financially. As use of health services increases, costs climb and health care takes a bigger bite of the country's national budget. That leads to curtailment of services, and politics is injected into medicine, the poll reveals.

The "E" May Disappear from HEW

The "E" will disappear from HEW if President Carter is successful in recently announced plans to remove Education from the Department of Health, Education, and Welfare.

As part of his plan for governmental reorganization, the President has announced appointment of a special commission to study the need for such a move. Insiders say, however, that the commission will be stacked to assure recommendation of the new department.

HEW was created during the Eisenhower administration. It has been cited by most of its former secretaries as impossible to administer.

Interesting enough, HEW has been emulated by many of the states, and little "Department of HEWs" have been created usually under the title of "Department of Human Resources." There have been many proposals over the past few years for creation of such a "department" in Mississippi.

BRIEF SUMMARY OF
PRESCRIBING INFORMATION

ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

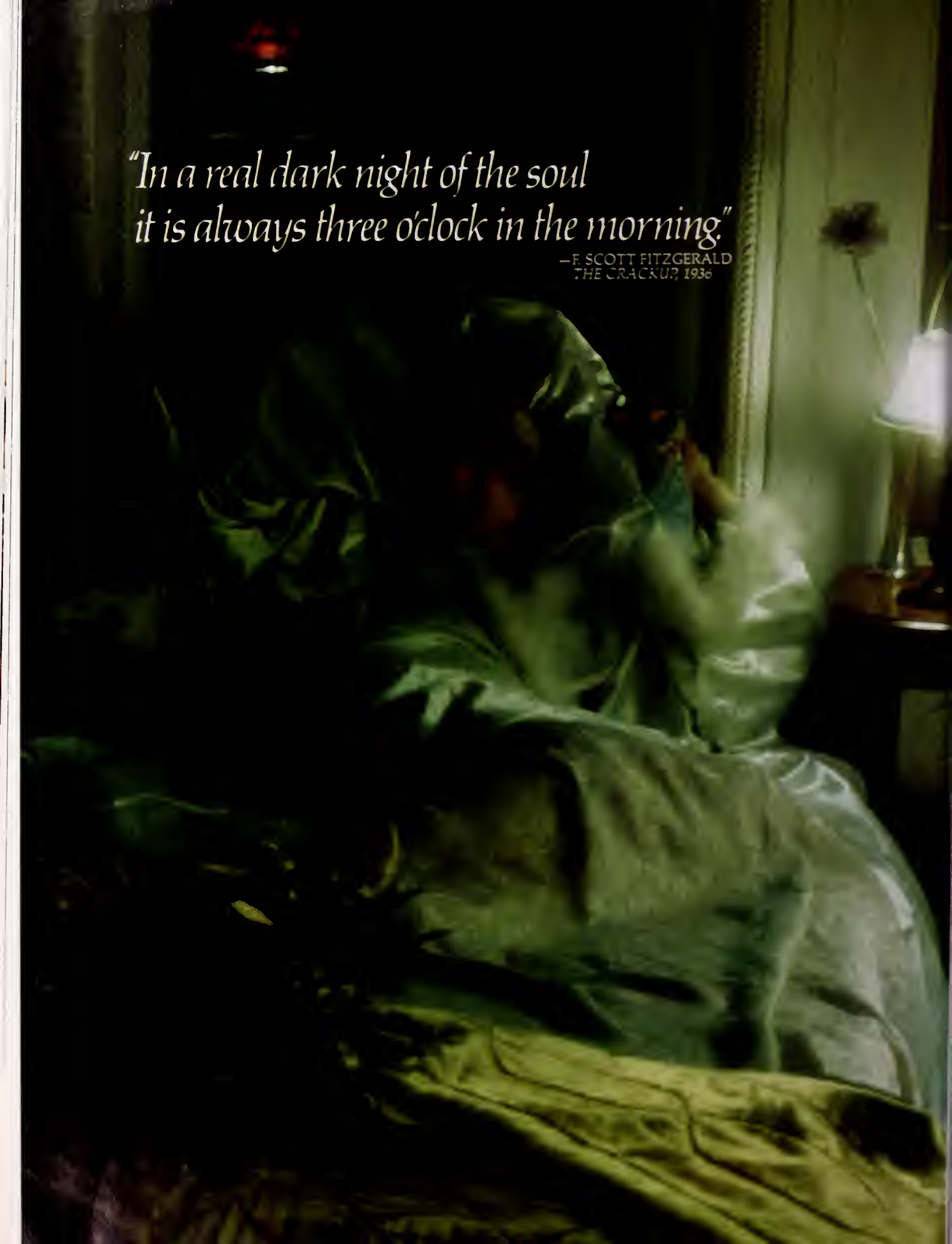
Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

More detailed professional information available on request.

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Pleasant tasting
Antiminth®
(pyrantel pamoate)
equivalent to 50 mg pyrantel/ml
ORAL SUSPENSION
a drug of choice in pinworm infections
Please see brief summary of prescribing information on facing page.
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it is always three o'clock in the morning."
—F. SCOTT FITZGERALD
THE CRACK-UP, 1936

Insomnia
a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin® (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime! Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information
ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, nor on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

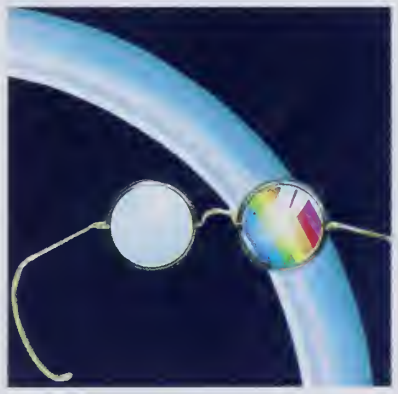
Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 25 mg t.i.d. Increase or decrease the dosage according to individual response. Daily dosage, up to 150 mg may be taken at bedtime without loss of effectiveness. Usual optimum daily dosage is 75 mg to 150 mg per day not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg, 50 mg and 100 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.

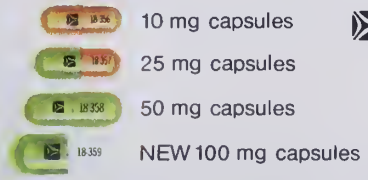


When they see life in shades of blue... help them see life in all its colors.

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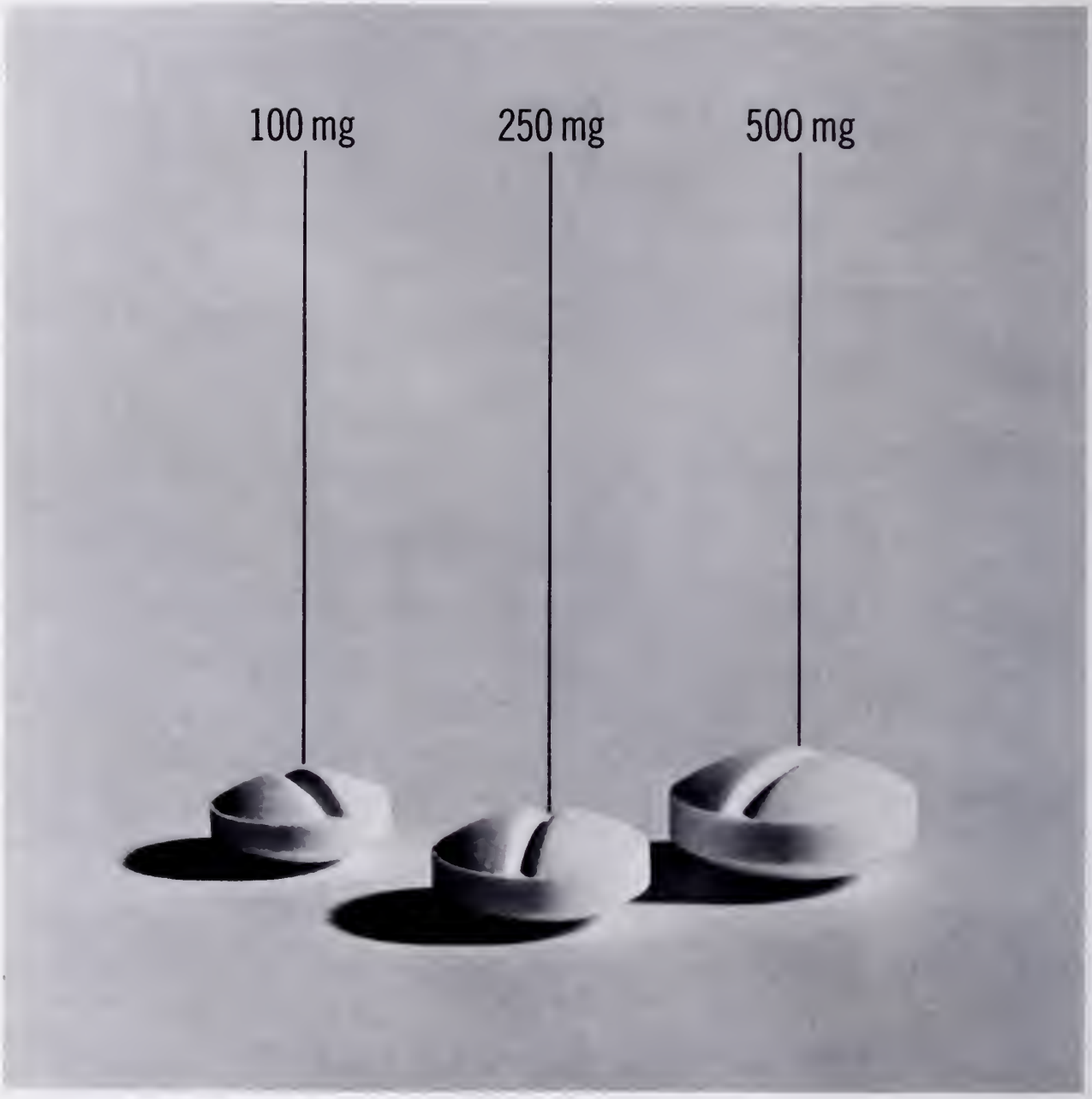
Adapin®
(doxepin HCl)

single daily dose recommended h.s.



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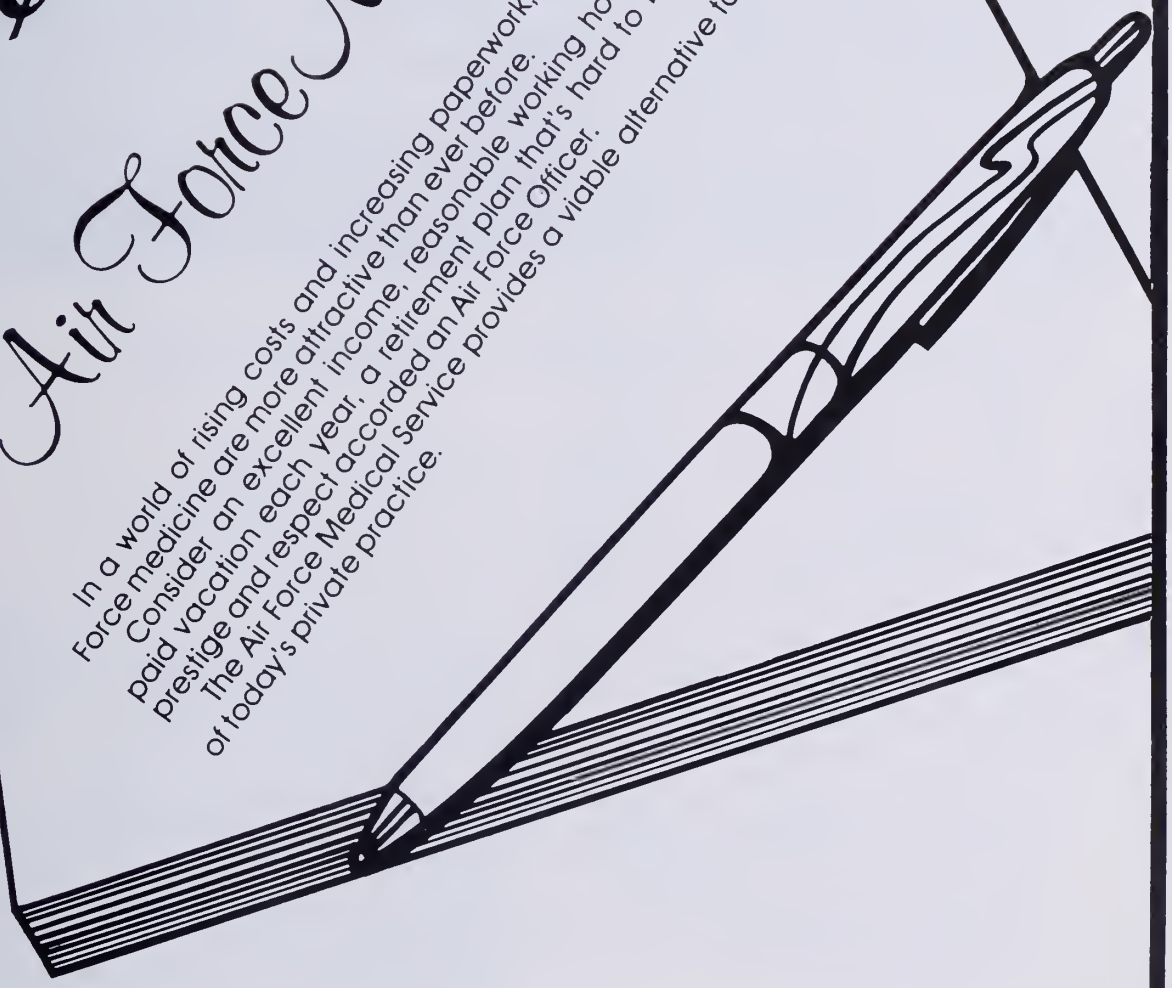
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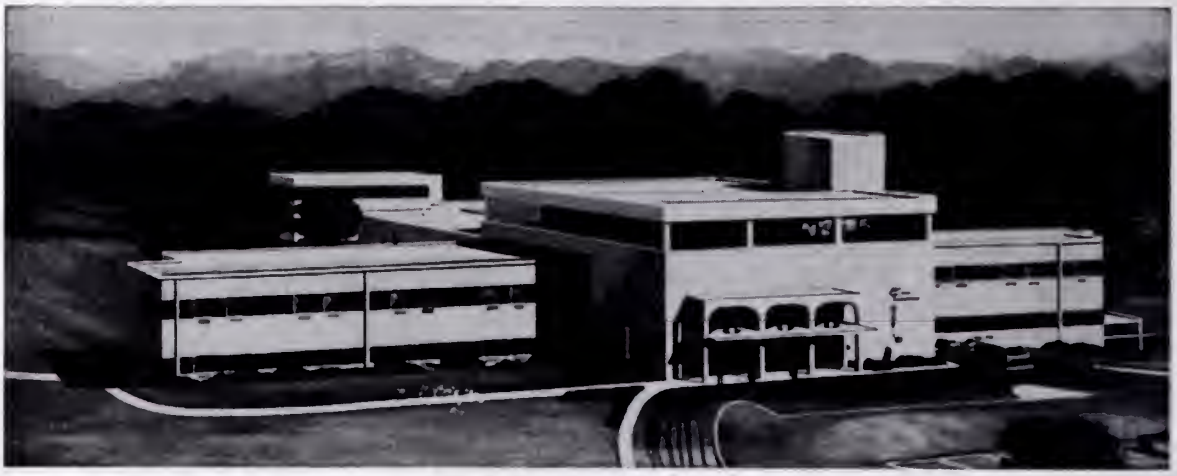
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
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ORIGINAL PAPERS

Clinical Diagnosis of Pleural Disease

JAMES E. GRIFFITH, M.D., and
GUY D. CAMPBELL, M.D.
Jackson, Mississippi

Abnormalities of the pleura, manifest clinically as pleural effusion or pleural thickening, are common clinical problems that often present a diagnostic challenge. When pleural effusion is clinically diagnosed, evaluation is indicated and can be accomplished by thoracentesis, pleural biopsy, chemical evaluation of the fluid, and fiberoptic bronchoscopy. Appropriate tests are cultures, blood count with differential, cytology, pH, and multiple chemical analyses, say the authors. Pathophysiology and etiology of pleural diseases are discussed in detail.

ABNORMALITIES of the pleura, manifest clinically as pleural effusion or pleural thickening, are common clinical problems that often present a diagnostic challenge. Pleural effusion is the most common problem and can result from pleural disease or an alteration of the hydrostatic forces that keep the pleural space dry. Pleural fluid may accumulate if there is an increase in pleural capillary hydrostatic pressure, increased pleural capillary permeability, decreased capillary colloid osmotic pressure, or pulmonary lymphatic obstruction. When pleural effusion is detected, evaluation for etiology is mandatory. When thoracentesis is performed for diagnostic purposes, a pleural biopsy should be performed and appropriate laboratory examination of the pleural fluid undertaken.

Examination of Pleural Fluid. It is important to distinguish between "transudative" pleural fluid and "exudative" pleural fluid. Transudative fluid is caused by a disturbance of the mechanical factors which influence the formation and removal of fluid from the pleural space. Exudative effusions occur in response to an inflammatory process or other diseases of the pleural surfaces. In transudative effusions the pleural surfaces are not thought to be involved in the primary process. When a transudative effusion is discovered, the underlying process should be sought and treated. However, when an exudative effusion is diagnosed, pleural disease is suspected and further workup indicated to establish its cause.

From the Medical Service, Veterans Administration Hospital, and Department of Medicine, University of Mississippi School of Medicine, Jackson, MS.

Classification of Transudates and Exudates. It is well accepted that transudates and exudates can be identified in over 95 per cent of effusions by the following criteria:[1]

Criteria	*Transudate*	*Exudate*
Fluid LDH	< 200	> 200
Fluid LDH/Serum LDH	< 0.6	> 0.6
Fluid Protein* / Serum Protein	< 0.5	> 0.5

* Protein is felt to be the most reliable.

Pleural Fluid pH. Measurement of the pH of pleural fluid has proven useful in two clinical situations. When an exudative effusion exists in which both carcinoma and tuberculosis are equally suspect, a pleural fluid pH of less than 7.30 is highly suggestive of tuberculosis, whereas a pH greater than

7.40 suggests malignaney. Intermediate pH values are of little diagnostic usefulness. The seeond situation involves a pleural effusion assoeiated with pneumonia. These "parapneumonie" effusions have the potential of beeoming empyemas or assuming empyema-like behavior. Pleural fluid pH of parapneumonic effusion less than 7.20 indieates the presence of viable organisms. The effusion tends to behave as an empyema and requires more aggressive management (see below).[2]

Pleural Fluid Glucose. The pleural fluid glueose is usually low to absent in rheumatoid pleuritis, but it is not of predictive value in other disease states without additional supporting evidenee.[3]

Pleural Fluid Amylase. Pleural fluid amylase may be elevated in patients with esophageal rupture, pancreatitis, or neoplasms involving the pleura. In pancreatitis, the amylase of an assoeiated pleural effusion is usually above the normal value of 160 units; in faet, it is usually higher than assoeiated serum levels. However, the amylase level may be normal initially and serial measurements are required to make the diagnosis.[3]

Cytology of the Pleural Fluid. Red Blood Cells (RBC)—As little as 1-2 ml. of blood in one liter of pleural fluid will produee blood-tinged fluid. Pleural fluid red eell eounts of up to 10,000/mm^3 and over may be assoeiated with transudates or exudates and thus have no elinieal signifieanee. Although the presence or absenee of blood in the pleural fluid is of no great value in diagnosing its etiology, in one large series RBC eounts greater than 100,000/mm^3 were highly suggestive of neoplasm, pulmonary infaretion, or trauma.

White Blood Cells (WBC)—Exeept in empyema, the total WBC count is of little value in the differential diagnosis of pleural effusions. However, the differential WBC eount may be of some value in the separation of exudative eauses of pleural effusions. The presenee of predominantly neutrophilic fluid indieates that it is a result of an aeute inflammatory process. The neutrophilia may be transient and last from one to five days. If the proeess is aeute, neutrophilia may be evideneed, but subsequent taps may yield only monoeulear fluid. Lymphoeytie fluid may be seen in a variety of eonditions, but only tubereulous and neoplastic exudates frequently have a lymphoeyte count exeeeding 50 per eent. Although pleural eosinophilia is of no particular value in the differential diagnosis of pleural effusion, signifieant eosinophilia makes tuberculosis or neoplasm unlikely. Eosinophilia is eommon in fluid associated with a pneumothorax. Blood eosinophilia is seldom manifested in the presenee of pleural eosinophilia.

The presenee of mesothelial eells in pleural fluid is eommon and their differentiation from abnormal eells and maerophages is not easy. Mesothelial eells may be absent from fluid arising from eonditions with extensive involvement of the pleural surfaces. Extensive inflammation leads to fibrin eoating of the pleural surfaees and lessens the ehanee of mesothelial exfoliation. The presenee of large numbers of mesothelial eells in the fluid virtually exeludes a diagnosis of tubereulosis, but their absence does not establish the diagnosis of tubereulous pleuritis. The only eells in the pleural fluid of etiologie importanee are malignant eells. In eytologie examination of the pleural fluid for malignant eells, most series report about 70 per eent aeeuraey. Repeat eytologie examinations of the pleural fluid with pleural biopsy are useful; in faet, some authors feel that submitting three separate speeimens will raise diagnostie aeeuraey to 90 per eent in those eases in whieh a malignant neoplasm direetly involves the pleura. Beeause neoplasms may eause effusion by means other than direet pleural involvement (lymphatie or bronehial obstruction, ete.), there will be a number of effusions due to malignant neoplasms with negative pleural fluid eytology.[4, 6]

Culture of the Pleural Fluid. Prior to the antibiotie era, about two-thirds of patients with empyema fluid grew S. pneumoniae. In more reeent years, S. aureus and the enterie gram negative bacteria have beeome more prominent. Also, the "sterile empyema" has beeome important. These are largely the result of anaerobie organisms and the failure of many laboratories to grow these organisms. Properly eultured, anaerobie organisms may be grown in three-fourths of all empyemas and will be the exclusive agent in about one-third. Culture of tubereulous pleural fluid will yield positive results in only 25 per eent of eases.[5, 8]

Biopsy

Pleural Biopsy. Tuberculosis, malignant neoplasm, and rheumatoid disease are the only conditions whieh may be definitely diagnosed by pleural biopsy, but other diagnoses may be inferred. The effieaey of the pleural biopsy alone in diagnosing neoplasia is about 60 per eent in most series. When pleural biopsy is eombined with pleural fluid eytology, diagnostie aeeuraey inereases to 90 per eent. In the diagnosis of tubereulous pleuritis, granuloma may be obtained in 70 per eent of speeimens, but

the positive identification of acid-fast bacilli by stain or culture is the only way to confirm the diagnosis conclusively. When biopsied pleural tissue is cultured, the average diagnostic accuracy in tuberculous pleuritis is 65 per cent.[6, 7, 8]

Fiberoptic Bronschoscopy. When the above procedures fail, fiberoptic bronchoscopy is certainly indicated.

Infectious Disease

Infectious Pleural Disease. Tuberculous Pleuritis—Tuberculous pleural effusion is probably the most common exudative pleural effusion to develop without demonstrable pulmonary disease. It is initially self-limited, although 65 per cent of patients will develop active pulmonary tuberculosis within five years if untreated. Only about one-third of patients who present with tuberculous pleurisy have parenchymal pulmonary disease at the outset. The initial 5 TU skin test is negative in one-third of patients, but when repeated later may be positive in a much higher per cent of patients. The fluid is exudative and rarely bloody; it has a variable glucose and is best diagnosed by a combination of pleural fluid and pleural biopsy culture and microscopic examination of special stains.[8]

Other Bacterial Infections—Klebsiella, staphylococcus, streptococcus, P. tularemia, and S. pneumoniae may produce parapneumonic effusion and/or empyema.

Fungal Infections—Actinomyces and Nocardia species are clearly the most important fungi in the etiology of pleural effusions, and pulmonary involvement is inevitable. Histoplasmosis, blastomycosis, and cryptococcosis rarely produce pleural effusion.

Parasitic Disease Involving the Pleura—Amebiasis may produce pleuropulmonary involvement secondary to liver abscess; effusion is usually exudative and frank empyema may develop due to secondary infection. Other parasites may also produce pleural effusion (Paragonemus westermani, Echinococcus granulosis).

Viral and Mycoplasma Infections—Pneumonia due to these conditions may produce an exudative pleural effusion with the characteristics of an acute inflammatory process.

Empyema—Classically, empyema is defined as pus in the pleural space. In patients with pneumonia, pleural inflammation occurs to some extent in almost all cases. The clinical spectrum ranges from minimal pleural involvement with slight pain and no fluid to opacification of a hemithorax with thick, frank pus, resulting in fibrinous pleurisy and restrictive fibrothorax. The pleural fluid white count is elevated and the pH is below 7.20 in "parapneumonic effusions" which behave as empyemas. "Behaving as empyema" implies that the effusion does not clear with appropriate antimicrobial therapy and thoracentesis, but requires more aggressive therapy including chest tube drainage or, in some cases, rib resection and open drainage. Early recognition of empyema is important because delayed diagnosis and lack of drainage may lead to fibrothorax which may require thoractomy and decortication.

Malignant Pleural Diseases. Primary Neoplasms of the Pleura—The two types of pleural mesothelioma are localized benign and diffuse malignant forms. The localized benign type is rarely associated with pleural effusion. Diffuse malignant mesothelioma is commonly associated with a pleural effusion which is often bloody and contains large quantities of hyaluronic acid. Malignant mesothelioma commonly presents as diffuse pleural thickening over much of the involved hemithorax and is commonly associated with pulmonary asbestosis.

Metastatic Neoplasms—Primary neoplasms metastatic to the pleura most commonly are from lung and breast, followed in frequency by stomach, ovary, kidney, and bladder. When pleural effusion presents as a manifestation of metastatic carcinoma, the primary site may be already evident or the effusion may be the initial manifestation. There is characteristically no fever and a high RBC count in an exudative fluid with a high pH (> 7.40). There is usually a continuous outpouring of fluid during the course of the disease making these effusions difficult to manage.

Management of Malignant Effusions—In the patient with a pleural effusion secondary to metastatic malignant disease, shortness of breath is a severe problem which can often be relieved only by adequate drainage of fluid and maintenance of a dry pleural space. Repeated thoracentesis is neither safe nor satisfactory for a number of reasons, e.g., rapid recurrence of fluid, risk of infection, pneumothorax, and protein depletion with eventual loculation of the fluid. We prefer to introduce an irritant substance through a closed thoracostomy, maintain suction, and achieve a chemical pleuritis with subsequent adhesion (pleural symphysis). Nitrogen mustard and tetracycline have been used with similar success rates (up to 80 per cent). The advantage of tetracycline is that it does not interfere with systemic chemotherapy as may nitrogen mustard.[9] External

beam irradiation by a moving strip technique also has been utilized with a similar success rate.

Non-Infectious Inflammatory Pleural Disease. Collagen Vascular Diseases—Only systemic lupus erythematosis (SLE) and rheumatoid disease commonly produce pleural effusion. In SLE the reported incidence of pleural disease varies widely (30-75 per cent). Effusions are usually small, but in the acute state may be massive. They are bilateral in half the cases, but when unilateral are usually left-sided. The fluid is exudative with no distinguishing chemical or cellular characteristics. Total complement, including C3 and C4, is low in pleural effusion in both SLE and in rheumatoid arthritis. Although rheumatoid disease is more prevalent in women, rheumatoid pleuritis is far more common in men. Pleural effusions are seen in 3-5 per cent of patients with rheumatoid disease. Most patients have long standing arthritis and are usually older. Pleural effusion may occur without radiographic evidence of associated lung disease in rheumatoid arthritis. The fluid characteristically has a low glucose (< 40 mg. per cent), a markedly elevated LDH (several thousand), and may exhibit eosinophilia. Needle biopsy of the pleura is recommended to rule out other causes of exudative pleuritis and for diagnosis if a rheumatoid nodule is present in the biopsy specimen. If the pleural biopsy is negative, this does not rule out rheumatoid pleuritis. A second or third biopsy is recommended if the initial effort is non-diagnostic. The occurrence of a rheumatoid effusion carries no prognostic significance but occurs in the natural history of rheumatoid arthritis. There is no specific treatment available for rheumatoid pleural effusion.[10]

Sarcoidosis of the Pleura—Pleural sarcoidosis, once considered rare, is now believed to occur in up to 10 per cent of patients. It is usually associated with extensive pulmonary parenchymal or extrathoracic involvement. Effusions when present may be transudative or exudative, and pleural biopsy will occasionally reveal non-caseating granuloma.

Other Causes of Pleural Effusion. Thromboembolic Disease—Effusion commonly accompanies pulmonary embolism with infarction. This effusion may develop with no other obvious chest film abnormality. Most effusions are small and about two-thirds contain blood. A large and densely bloody effusion should be removed to prevent fibrothorax.

Traumatic Causes—With chest injury, blood may enter the pleural space from the chest wall, mediastinum, diaphragm, or lung. Hemothorax may develop with no evidence of fracture. Blood coagulates rapidly in the pleural space, leaving free fluid with an x-ray film appearance similar to any other fluid. Hemothorax should be promptly and adequately drained to prevent restrictive fibrinous pleurisy and resultant fibrothorax.

Foreign Bodies—A foreign body may result from fragments off a penetrating missile or be left in the pleural space at surgery. This foreign body may produce a chronic empyema.

Esophageal Rupture—Pleural effusion can occur and is almost always left-sided. Identification of ingested material in the pleural fluid is diagnostic. The pleural fluid pH is usually low and a high amylase concentration is consistently found.

Asbestosis—Inhalation of asbestos commonly leads to pleural disease manifest by pleural thickening, pleural calcification, and occasionally exudative pleural effusion.

Pancreatitis—About 10 per cent of patients with pancreatitis develop pleural effusion. It is usually left-sided, exudative, and has a high protein and amylase content. The pleural effusion is believed to be caused by fluid traversing the diaphragm via lymphatic channels. Effusions may become chronic and represent fistulae draining into the pleural space.

Dialysis—Peritoneal dialysis may produce a hydrothorax, the fluid presumably arriving in the thorax through diaphragmatic lymphatics. Chronic hemodialysis is associated with pleural effusion. At autopsy 20 per cent of all uremic patients exhibit fibrinous pleurisy. Pleural effusions are exudative, often bloody, and usually have high lymphocyte counts. They are felt to be directly related to the uremic state. Fibrinous pleurisy may result in a restrictive fibrothorax requiring thoracotomy and pleural decortication.

Low Protein States—Transudative effusions occur in severe hepatic disease, chronic debility of any form, malabsorption states, nephrotic syndrome, and malnutrition. These effusions are accompanied by low serum protein levels and consequent decreased colloid osmotic pressure as the colloid osmotic pressure is the chief force keeping the pleural space dry.

Increased Capillary Pressure—Congestive heart failure may produce increased pleural capillary pressure which is the principal agent promoting transudation in the pleural space. Increased capillary pressure may also be seen with superior vena caval obstruction, constrictive pericarditis, or fluid overload as in renal failure. These conditions may also be as-

sociated with low osmotic pressure states which compound the likelihood of effusion. Such effusions are transudative but may contain small amounts of blood. Pleural effusion associated with congestive heart failure may develop in the interlobar fissures, especially the right horizontal or "minor fissure"; the resultant fluid collections are known as "phantom tumors."

Summary

When pleural effusion is clinically diagnosed, evaluation is indicated. This is accomplished by thoracentesis, pleural biopsy, chemical evaluation of the fluid, and fiberoptic bronchoscopy when indicated. Appropriate tests are cultures (of fluid and biopsy), complete blood count with differential, cytology, pH, and multiple chemical analyses. Pathophysiology and etiology of pleural diseases are discussed. ★★★

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A clerk was helping a share-cropper fill out papers to begin receiving Social Security payments. "Do you belong to the Communist Party or to any group that plans to overthrow the government?" asked the clerk.

"Yup."

Taken aback at the old man's candor, the clerk asked, "which one?"

"The Democrats."

Pain in Malignancy: Cordotomy

ROBERT A. SANFORD, M.D., and BERNARD S. PATRICK, M.D.
Jackson, Mississippi

CORDOTOMY, first performed in 1911, is the most soundly conceived neurosurgical procedure for the relief of intractable pain of malignancy. Relief of pain can be achieved with no greater expense than the loss of appreciation of pain and temperature by interruption of the lateral spinothalamic tract within the spinal cord. It is highly successful in the relief of somatic pain such as seen with the compression of tissue, nerve root invasion and constriction by expanding tumor. (See Figure 1.)

At the present time, there are two types of cordotomies: open and closed. The open cordotomy is a surgical procedure which requires general anesthesia, a limited laminectomy and actual surgical section of the lateral spinothalamic tract under direct vision.

The second type, the percutaneous cervical cordotomy, is performed under local anesthesia in the x-ray department. An electrode is introduced into the spinal cord percutaneously and a electrolytic lesion is produced interrupting the lateral spinothalamic tract. The unilateral high percutaneous cordotomy has reached a stage of technical evolution that permits its use with a very low rate of complication. Its advantages over the open cordotomies are obvious. It can be performed on seriously ill patients with local anesthesia and without a prolonged convalescent period. The patient may be discharged from the hospital 24 hours following percutaneous cordotomy.

Cordotomy is an operation of precision. Despite the apparent advantage of superior visibility of the open over the percutaneous technique, the percutaneous technique offers the greatest accuracy. Percutaneous cordotomy utilizes a more reliable means of lesion localization than mere visual inspection. The electrode placement is verified with the measurement of impedance and stimulation before the lesion is produced. The safety of percutaneous cordotomy has been repeatedly demonstrated. The procedural steps are as follows: Under fluoroscopic control an 18-gauge spinal needle is positioned in the spinal canal between C-1 and C-2 just anterior to the dentate ligament on the side opposite the patients' pain. This position is verified by layering emulsified Pantopaque along the dentate ligament. This placement of the needle is quite safe. Following this, a teflon coated steel electrode with a two millimeter bared tip is then inserted into the spinal cord. The needle is placed anteriorly to the well-delineated dentate ligament. (See Figure 2.) As the electrode penetrates the spinal cord, impedance is measured.

This is the fourth in a series of articles dealing with pain associated with malignant neoplasms. The current article covers cordotomy which the authors say is the most soundly conceived neurosurgical procedure for the relief of intractable pain of malignancy.

Impedance is a measurement of the different electrical resistance (impedance) to flow of current from the electrode tip in cerebrospinal fluid and in spinal cord tissue. The impedance meter rises from 150-250 ohms in CSF to 350-750 ohms as is inserted into the spinal cord. Following this maneuver, the electrode is then stimulated at 60 cycles/sec. with very low voltage. If the electrode is properly located, stimulation will produce the appropriate sensory response of tingling on the opposite side of the body. The electrode can then be repositioned as necessary within the cord to limit the level of anesthesia. It is possible, following this method, to selectively produce loss of pain and temperature in the upper or lower extremity. (See Figure 3.)

If a motor response is obtained by stimulation, it indicates that the electrode is on the border of the corticospinal (motor) tract. The electrode is then safely repositioned.

Following this very accurate localization of the electrode, an electrolytic lesion is slowly formed. The first lesion stage is typically five seconds in length. The patient is then tested to determine the area and degree of loss of pain and temperature. The lesion can gradually be increased in size and density until

From the Department of Neurosurgery, University of Mississippi Medical Center, Jackson, MS.

pain reduction is satisfactory. It is possible with percutaneous cordotomy to bring the level of pain up to C5. This will quite effectively relieve brachial plexus, arm and chest wall pain.

Tarren successfully located the spinothalamic tract in 196 out of 199 consecutive procedures. He achieved a 90 per cent incidence of immediate pain relief. In unilateral cases the percentage of satisfactory pain relief dropped to 85 per cent at a six month follow-up.

The percutaneous technique has almost eliminated paresis due to corticospinal tract damage. The risk of aggravating bladder dysfunction is approximately six per cent in unilateral and 21 per cent in bilateral percutaneous cordotomy. This complication rate is only slightly better than open operation.

Bilateral cordotomy is necessary for bilateral pain. The most serious complication of bilateral percutaneous cordotomies is the respiratory impairment. However, it is possible to avoid this problem by placing one lesion at the C1-2 level and the second lesion low at the C6-7 level below the level of the origin of the phrenic nerve. This is done by the Lin technique with an anterior approach through the intervertebral disc, rather than laterally at C1-C2. Also, the procedures may be spaced in time with a two to three week interval separating the procedures.

Cordotomy should be offered to patients with pain of malignant disease when it becomes apparent that they are going to require narcotics for control of pain. Early utilization of pain procedures prevents physical addiction and allows patients to remain functional and pain free. Pain relief by cordotomy will last two to five years; therefore, it has certain limitations in patients who are expected to survive longer than this period of time.

Relief of pain of the head and neck is a most difficult problem. Obtaining satisfactory anesthesia with relief of pain in this region requires high sections of the spinothalamic and quintothalamic tract. Both the spinothalamic and quintothalamic tract converge in the mesencephalon and are accessible at that level. However, section of the lateral spinothalamic tract in the mesencephalon is associated with a high rate of persistent dysesthesias.

Sterotaxic radio frequency coagulation lesions can

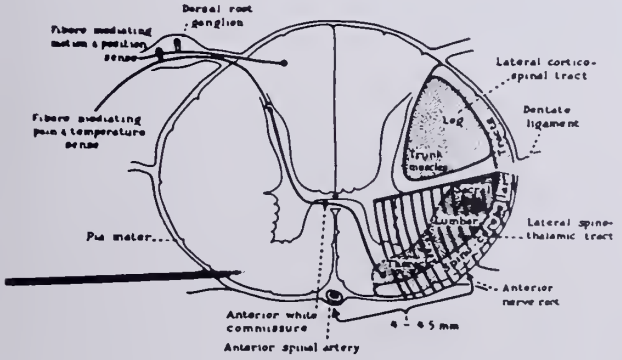


Figure 1



Figure 2

be produced in the dorsal lateral tegmentum of the mesencephalon and are associated with a somewhat lower complication rate, but dysesthesias continue to limit the operation.

Medullary spinal tractotomy can be performed by an open procedure with section of the tract just dorsal to the inferior olive. This procedure has not gained wide acceptance because of its technical difficulties and the frequent postoperative ataxia. The spinothalamic tract lies dorsal to the inferior olive at a depth of approximately five millimeters just rostral to the vagal rootlet. The trigeminal tractotomy for relief of pain of the face is more limited,

however, than section of the fifth nerve. The percutaneous technique for medullary tractotomy is still in the experimental stage.

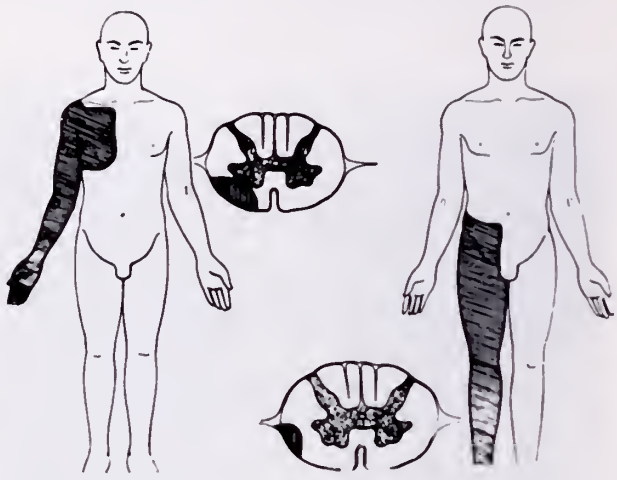


Figure 3

Summary

In summary, cordotomy should be offered to patients for relief of the pain of malignancy. Percutaneous cervical cordotomy is a safe method with low morbidity for relieving cancer pain. This relief of pain with freedom from narcotics is extremely beneficial. ★★★

2500 North State Street (39216)

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The first grade teacher assured her class that any one of them could become President of the United States. "Even me?" asked young Clyde.

"Yes, Clyde, you certainly could."

"But what if they find out I can't tie my shoelaces?"



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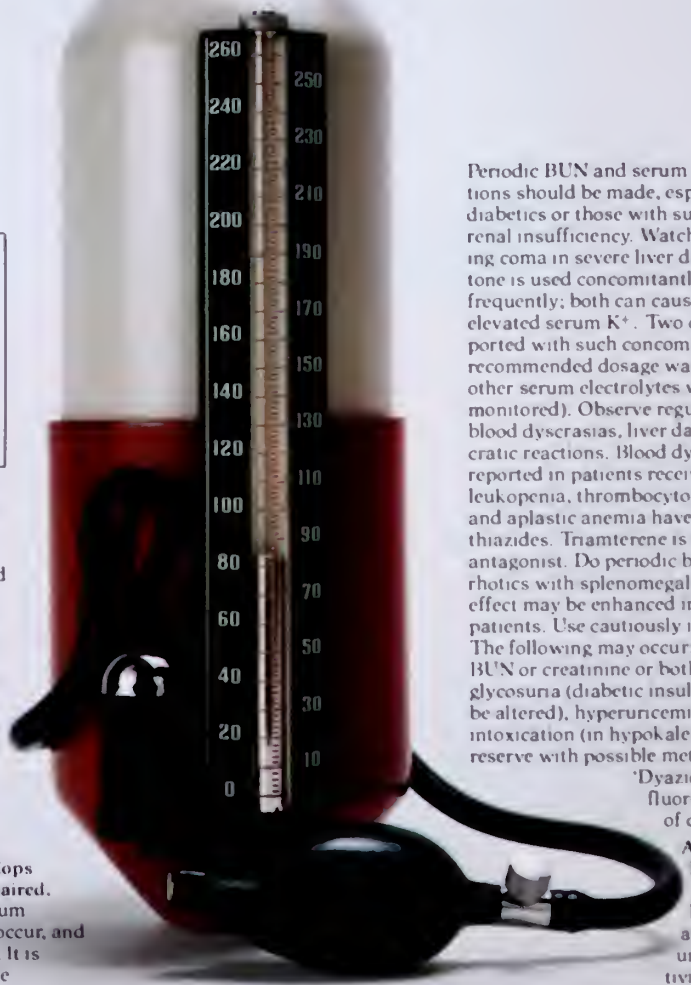
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* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

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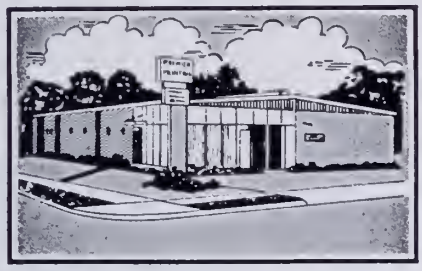
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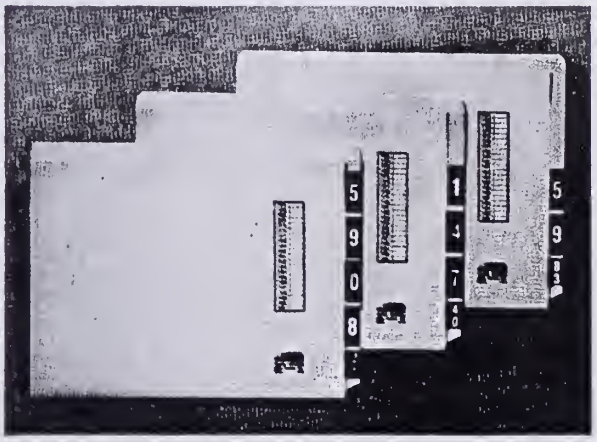
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Radiologic Seminar CLXXIX: The Case for the Clean Colon

R. B. ELLISON, M.D.
Jackson, Mississippi

CANCER OF THE COLON is second in incidence only to skin cancer and, as a cause of death, is second only to lung cancer.[1]

Early diagnosis and surgery for cancer of the colon usually means a cure while a delay in diagnosis may result in a 15 to 20 year loss of life.[2]

Data published by Cooley reveals that one cancer in four is missed on the first barium enema,[3] usually because the cancer is mistaken for feces. In fact, 75 per cent of these missed carcinomas of the colon were either hidden by fecal material or mistaken for fecal material.[4]

Morson has presented evidence that colon cancer evolves in a polyp-to-cancer sequence which takes from 5 to 25 years.[5] As a result of studies by Morson and others, it appears that a tumor 5 cms in diameter must have been present and detectable as a polyp for 3 to 5 years. Considering the relatively slow growth rate of a colon cancer, Figiel has stated that if a colon cancer is found within 2 years of a previously "normal" barium enema, the polyp or early cancer was present and was missed at the time of the prior exam.[6]

It stands to reason that a poor examination of the colon is worse than none at all, since a false sense of security may result from the radiologist having done the initial poor study and having rendered a report which may lend itself to different interpretations. Such a report might read: "Polyps cannot be ruled out due to fecal material remaining in the colon, but no constricting lesions are seen." The referring clinician (perhaps considering that a barium enema at best creates an unglamorous situation for the patient, is often uncomfortable to the patient, and sometimes is resisted by the patient), may choose to delay, possibly indefinitely, a repeat barium enema. No matter how the radiology report is worded or for whatever reasons the colon is not properly cleansed or not re-examined, failing to find the tumor may be an irreversible error.

Several examiners have reported that high quality barium studies of well cleansed colons can detect up to 98 per cent of polyps larger than 1 cm in diameter and up to 95 per cent of polyps over ½ cm in diameter. Polyps 1 cm or larger become important because of their malignant potential. Morson has shown that 1.3 per cent of polyps less than 1 cm in diameter are malignant, that 9.5 per cent of polyps between 1 and 2 cms in diameter are malignant and that 46 per cent of polyps above 2 cms in diameter are malignant.[5] A 10 year survival rate of 81 per



Figure 1

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Veterans Administration Hospital, Jackson, MS.

cent can be expected with early diagnosis and resection of colon carcinoma while a 10 year survival rate of only 14 per cent can be expected with extensive lesions.[7] The cleansing enema, by allowing discovery of earlier lesions, might therefore be considered an effective "life saving" procedure.

In an effort to improve colon cleansing and to improve diagnostic accuracy, some radiologists insist that a final cleansing enema be done in the radiology department. The design of the radiology department plus shortages of space and plumbing facilities may, however, make this approach less than ideal for many departments. Regardless of where the cleansing enema is accomplished, the importance of the cleansing enema must be explained and stressed to the individual whose job it is to prepare the patients for their barium enema.

Rogers states that castor oil and enemas can result in 95 per cent clean colons on the first attempt at barium enema.[8] Certainly no colon cleansing regimen is foolproof and undoubtedly many widely varying regimens are effective if they are pursued with dedication. The following regimen has been found by the author to be generally practical and, if followed reasonably carefully, to result in only an occasional repeat barium enema because of inadequate colon cleansing:

1. 24 hour clear liquid diet (broth, Coca-Cola, black coffee, 7-Up, Jello, tea and syrup from canned fruits).
2. 8 glasses of clear liquid (approximately 8 ounces each) the day prior to the examination.
3. 2 ounces of castor oil either before or immediately after the evening meal prior to the day of examination.
4. A maximum of 3 cleansing enemas utilizing 1,000 to 2,000 CC's of body temperature water or saline on the morning of the examination.

Finally—Please, do as I say, not as I do! The poorly cleansed colon in Figure I cleverly concealed a villous adenoma of the rectum, a 4.5 cm carcinoma of the transverse colon, a polypoid adenocarcinoma of the recto-sigmoid, two 15 mm in diameter sessile adenocarcinomas in the ascending colon and multiple scattered adenomatous polyps. Fortunately the delay in diagnosis was only a matter of days before a repeat barium enema revealed ample reasons for rectal bleeding.

Summary

The relatively high incidence of carcinoma of the colon, slow growth rate of the cancer, and marked difference in survival between early and late diagnosis are noted. The importance of adequate colon cleansing prior to a barium enema is stressed and a colon cleansing regimen is offered. A case of multiple colon tumors concealed by fecal material is presented. ★★★

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Premature deaths from cigarette-caused diseases total 300,000 yearly. The Mississippi Lung Association advises "No Smoking—for life and breath." No Smoking signs and information are available, free of charge, from the Mississippi Lung Association, P. O. Box 9865, Jackson, MS 39206.



The President Speaking

Public Ambivalent on Health Care

JAMES O. GILMORE, M.D.
Oxford, Mississippi

Last October HEW conducted more than 100 hearings around the country to assess public opinion on national health insurance (NHI).

Now HEW has published its distillation of the people's voice, saying among other things that the nation wants a NHI system to "build on the strengths of the existing system, reflect the lessons learned in other countries having 'mature' health insurance programs, develop approaches for coping with the current and anticipated cost pressures, and stress preventive care and health education efforts."

Over 8,600 individuals and organizations presented their views at the hearings and the report, written largely by HEW staff in the Atlanta Regional Office, says "while these hearings demonstrated that a majority of the American public favors development of a NHI plan, there was no agreement on the type of plan we should establish." The report is titled "The National Health Insurance National Outreach Report."

I personally feel that the public is ambivalent in its desires for health care and the conclusions from the HEW hearings appear to strengthen this observation.

If further evidence is needed a recent public opinion poll conducted for the Robert Wood Johnson Foundation by the University of Chicago provides it. In that poll some 88 per cent of the public stated they were satisfied with their present health care but then 60 per cent stated they felt there was a "crisis" in health care today.

Perhaps the reason for this public ambivalence lies mainly in the almost daily "bad press" medicine receives from a number of sources particularly those in favor of a NHI program vis-à-vis the British program. If so, it behooves us to remember that there are some 2.9 million contacts between patients and physicians daily. It is the public's impression from these contacts that will establish true public opinion and the future direction of health care in our country.

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XIX, NUMBER 3
MARCH 1978

The LeVeen Peritoneal-Jugular Shunt

An ingenious little valve developed by Dr. Harry LeVeen has given a new lease on life to patients suffering with intractable ascites. Easily buried beneath the abdominal wall, the valve receives ascitic fluid from an intraperitoneal perforated tube. When the intra-abdominal pressure exceeds three centimeters of H_2O, the valve opens and ascitic fluid passes through a subcutaneous tube implanted into the superior vena cava via the internal jugular vein.

The postoperative effect is usually quite dramatic. These patients pass huge volumes of urine, often as much as four to five liters in 24 hours. The abdominal distention disappears; the BUN falls; electrolytes stabilize; and serum protein values improve. The patients are much more comfortable due to relief from pressure symptoms and are relieved of the necessity of repeated paracentesis.

The most common indication for a LeVeen shunt is cirrhosis of the liver. Obviously, the cirrhosis is not helped by this procedure but the quality of living is certainly enhanced.

GEORGE H. MARTIN, M.D.
Associate Editor

Medico-Legal Brief

Anesthesiologist Not Liable for Patient's Cardiac Arrest

An anesthesiologist was not liable for a severe neurological deficit suffered by a five-year-old patient who had a cardiac arrest during surgery, a Louisiana appellate court ruled.

About 45 minutes into an operation to correct a kidney disorder, the patient suffered the cardiac arrest. Resuscitation procedures restored his heartbeat within a minute of the report of cardiac arrest. As a result, he suffered a severe neurological deficit which rendered him practically helpless.

Claiming that the anesthesiologist failed to constantly monitor his vital signs, the patient filed suit against him and others. A jury returned a verdict in favor of the anesthesiologist and the other defendants.

On appeal, the court affirmed the decision. The anesthesiologist testified that he had left the operating room for about five minutes during the operation to answer a telephone call but that he was relieved by a qualified nurse-anesthetist. Both testified that the patient's vital signs were constantly monitored. The court said that the patient had not shown that the anesthesiologist had violated the standard of care required in the area.

The *res ipsa loquitur* doctrine did not apply because a statistically significant number of cardiac arrests occur on the operating table of unknown causes without negligence. The doctrine could not be used to presume negligence on the part of the anesthesiologist, the court concluded.—*McAdams v. Holden,* 349 So.2d 900 (La. Ct. of App., June 13, 1977; rehearing denied, Aug. 24, 1977); cert. denied, 351 So.2d 176 (La. Sup. Ct., Nov. 4, 1977)

AMA Begins Public Campaign

The American Medical Association is planning a $700,000 advertising campaign, starting in March, to enhance the public's image of doctors and defeat "the more radical national health insurance proposals."

According to Dr. James H. Sammons, AMA executive vice president, "the present day politics of medicine calls for concentrating on what is wrong. The ad campaign will act as a counter-balance. Our campaign will be informational and factual."

Previously, the American Hospital Association launched a two-part, $125,000 ad campaign to promote the public's understanding of hospitals, explain why hospital costs are so high and what hospitals are doing to control them.

DEATHS

ST. GERMAIN, ELLIS L., Ft. Lauderdale, FL. Born Breaux Bridge, LA, Jan. 8, 1906; M.D., Tulane University School of Medicine, New Orleans, LA, 1929; interned Charity Hospital, New Orleans, 1929-31; EENT residency, EENT Hospital, New Orleans, 1940-42; emeritus member of MSMA and AMA; age 71.

PERSONALS

WILL K. AUSTIN of McComb has been elected a fellow of the American College of Surgeons. Dr. Austin is serving as chief of surgery at Southwest Mississippi Regional Medical Center and is vice president of South Central Medical Society.

VICTOR T. BAZZONE of Gulfport announces the relocation of his office for the practice of neurological surgery to Omega Professional Building, Suite A, 15th Street and 45th Avenue, Gulfport.

RONALD P. BOREN of Houston has been elected president of the Houston Hospital medical staff. Vice president is PAUL J. VILARDI and secretary is ROLAND BUCKALEW.

FRANK R. BRIGGS, H. RICHARD JOHNSON, WALTER R. JONES, JR., ANTHONY B. PETRO and RICHARD L. YELVERTON of Jackson announce the formation of The Lakeland Surgical Clinic, Suite 310, St. Dominic Medical Offices, 971 Lakeland Drive, for general, thoracic and vascular surgery.

THOMAS R. BRYANT and GLENN F. MORRIS of Jackson announce the association of ISAAC AULTMAN for the practice of family medicine at 385 Medical Drive, adjacent to Doctors Hospital in Jackson.

R. E. CALDWELL of Baldwyn announces the relocation of his office to the building on the corner of Lee Street at Highway 45 South.

FRANCISCO CAMERO announces the opening of his office for general practice at 1500 45th Avenue, Omega Medical Arts Center in Gulfport.

RUSSEL CHAUVIN announces the opening of his office for the practice of general surgery at 1000 Fifth Avenue in Picayune.

ROBERT COGHLAN of Aberdeen has been elected president of Northeast Mississippi Medical Society. President-elect is SAM GALLOWAY of Booneville and secretary is JAMES COOPER of Tupelo.

WOODY DAVIS and ROBERT DILWORTH of Meridian have been named to the board of St. Joseph's Hospital. Dr. Davis is currently serving as chief of the medical staff.

A. P. DURFEY, SR., of Canton was honored with the Golden Deeds Award by the Canton Exchange Club.

O. LYNN HAMBLIN announces the opening of his office for the general practice of medicine at Calhoun City Clinic Building in Calhoun City.

J. ED HILL of Hollandale has been appointed to the Committee on Constitution and Bylaws of the American Academy of Family Physicians.

JACK SARTIN of Clarksdale has been elected president of the Clarksdale and Six Counties Medical Society. HENRY A. MCCRORY of Clarksdale is secretary.

ELLIS M. MOFFIT of Jackson is president of Central Medical Society and FRED L. MCMILLAN of Jackson is secretary.

J. B. PATEL announces the opening of her office for the practice of general medicine at Community Medical Center in Soso.

JOHN A. PORTER of Brookhaven has been elected to fellowship in the American College of Obstetricians and Gynecologists.

ROGER H. REED announces the relocation of his practice of general medicine to Dedeaux Road in Biloxi.

DAVID D. RICHARDSON of Louisville is president of the East Mississippi Medical Society. GEORGE L. ARRINGTON, JR., of Meridian is secretary and ROBERT M. GRAHAM of Meridian is president-elect.

FRED SANDIFER, JR., of Greenwood is president of Delta Medical Society. WALTER ROSE of Indianola is secretary and ARTHUR LINDSEY of Cleveland is president-elect.

LEO SCANLON of Vicksburg is president of West Mississippi Medical Society. M. E. HINMAN of Vicksburg is secretary and BARRY HOLCOMB is president-elect.

ROBERT SMITH and DURWARD BLAKEY of Jackson discussed diseases in the black community on Mississippi ETV's "Faces" during January.

W. GRANVILLE TABB of Jackson announces the relocation of his office for the practice of ophthalmology to Suite 215, Medical Arts Building, 1151 North State Street.

R. R. TADROS has reopened his office in the Medical Arts Building, North Panola Regional Hospital in Sardis, for the practice of general and vascular surgery.

H. M. WADSWORTH, SR., of Hernando is president of Desoto County Medical Society. M. D. BAXTER is secretary.

NEW MEMBERS

CAINE, CURTIS W., JR., Natchez. Born New Orleans, LA, Nov. 27, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned Baptist Memorial, Memphis, TN, one year; pediatric residency, Letterman Army Hospital, San Francisco, CA, Jan. 1973-Dec. 1973; anesthesiology residency, Duke University, Durham, NC, Jan. 1975-Dec. 1976; pediatric anesthesiology residency, Lebonheur Children's Hospital, Memphis, TN, Jan. 1977-Dec. 1977; elected by Homochitto Valley Medical Society.

KUIPER, HENDRIK K., Vicksburg. Born Arnhem, Holland, June 26, 1944; M.D., Sydney University, Sydney, Aus., 1969; interned Royal New Castle Hospital, one year; elected by West Mississippi Medical Society.

MADARA, JOSE, Booneville. Born Iriga City, Philippines, July 3, 1944; M.D., Far Eastern University, Manila, Philippines, 1967; interned Beth Israel Medical Center, Newark, NJ, June 1968-June 1969; elected by Northeast Mississippi Medical Society.

SUBER, BARRY D., Natchez. Born Louisville, MS, Mar. 12, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned Mobile General Hospital, Mobile, AL, 1971-72; internal medicine residency, University of South Alabama, Mobile, 1972-75; elected by Homochitto Valley Medical Society.

POSTGRADUATE CALENDAR

March 30-April 1, 1978
GASTROENTEROLOGY UPDATE
Ramada Inn Coliseum, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Medicine Division of Digestive Diseases and the University Medical Center Division of Continuing Health Professional Education.

Coordinator: James Achord, M.D., professor of medicine and director of the division of digestive diseases, University of Mississippi School of Medicine.

The three-day course will be presented by an outstanding guest faculty. Topics to be discussed will help bring the practicing physician up-to-date on new advances and concepts in gastroenterology. Advance registration is required. Fee: $150.00. Credit 18 contact hours, 1.8 CEU, AMA Category I; AAFP.

April 13-14, 1978
NEWBORN RESUSCITATION
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics Division of Newborn Medicine and the University Medical Center Division of Continuing Health Professional Education.

Coordinator: Gwendolyn Bussa, M.N., assistant professor of Nursing, University of Mississippi School of Nursing, and instructor in obstetrics and gynecology, University of Mississippi School of Medicine.

Participants will learn more about the manual skill of resuscitation through lectures and practice sessions during this two-day course. Management of the mechanical and pharmacologic needs of the resuscitated newborn will be stressed. The course is limited to six participants. Fee: $50.00. Credit: 15 contact hours, 1.5 CEU, AMA Category I; AAFP.

All continuing education correspondence should be addressed to: Continuing Health Professional Education, University Medical Center, 2500 North State Street, Jackson 39216.

FUTURE CALENDAR

May 5-6, 1978
THE INSULIN DEPENDENT DIABETIC
Holiday Inn Medical Center, Jackson

May 11-12, 1978
NEWBORN NUTRITION
University Medical Center, Jackson

May 19-20, 1978
ADVANCED CARDIAC LIFE SUPPORT
University Medical Center, Jackson

May 25-26, 1978
AGING
University Medical Center, Jackson

POSTGRADUATE / Continued

May 25-26, 1978
NEWBORN RESUSCITATION
University Medical Center, Jackson

June 12-23, 1978
NEWBORN CARE FOR PHYSICIAN AND NURSE TEAMS
University Medical Center, Jackson

Death Certificate Filing Improves

A study of new regulations dealing with the filing of death certificates in Mississippi indicates that the regulations have reduced the average number of days for filing a certificate by 4.5 days.

The regulations were issued by the Mississippi State Board of Health several months ago in an effort to reduce the time for filing such certificates.

Death certificates are necessary to settle insurance and estate matters and concerns about the timeliness of their filing was brought to the attention of the Board of Health by families of deceased persons.

Prior to implementation of the new regulations which removed primary responsibility for initiating death certificates from funeral homes to hospitals, it took an average of 19.4 days for the certificates to be filed. Under the new regulations the average has been cut to 14.9 days.

MSMA Comments on Health Plan

MSMA has officially commented on the State Health Plan submitted by the governor's State Health Planning and Development Agency under requirements of Public Law 93-641, the National Health Planning and Resources Development Act.

In a letter to the agency, MSMA Board Chairman, R. S. Caldwell stated that "the plan offered much promise but little chance for accomplishment" based on the health plan's goals being so grandiose and not addressing identified health needs.

"There is no way all the health goals in the plan can be effectively addressed in 10 years much less the projected five years, and as a matter of fact," Dr. Caldwell continued, "some of the goals have been addressed for the past 10-20 years and still haven't reached fruition—i.e. an Emergency Medical Services System, a reasonable population ratio of physicians, nurses and dentists."

"Our state's 'health problems' whether it be shortages of health professionals, infant mortality, or some other politically popular health statistic, are reflective of other socioeconomic problems and cannot be solved in isolation from those problems," Dr. Caldwell stated, "and our state faces some hard choices in allocating limited economic resources to correct 'health problems.' " "Are we to have funding for training more health professionals instead of funding for education, highway and other popular public needs and necessities?" Caldwell continued.

Addressing other specific points of the health plan, Dr. Caldwell urged that artificial boundaries such as county lines and Economic Development Districts not be used to describe needs for health resources. He noted too that the plan appeared to encourage two systems of health care—one for those able to pay for health care and one for those unable to pay for such care—with the latter lacking in two important aspects of quality medical care—continuity of care and a physician/patient relationship.

Medical Center Adds to Faculty

Two new assistant professors and an instructor have been named to the faculty at the University of Mississippi Medical Center.

UMC Vice Chancellor Norman C. Nelson announced the appointments following approval of the Board of Trustees, Institutions of Higher Learning.

The new faculty includes Dr. Timothy Summers, assistant professor of psychiatry in the School of Medicine. Joining the centerwide faculty are Dr. George Ronald Diepstra, instructor in physiology and biophysics, and Dr. Allan L. Staiman, assistant professor of pharmacology and toxicology.

Dr. Summers comes to the Medical Center from Topeka, KS, where he has been on staff at the C. F. Menninger Memorial Hospital since last July. The Tougaloo College and University of Illinois alumnus earned the B.S. degree at Jackson State University in 1969 and the M.D. degree at the Medical Center in 1974. Dr. Summers took residency training at UMC and at the Menninger School of Psychiatry in Kansas.

Dr. Diepstra comes to the Medical Center from the University of Texas Health Science Center in Dallas where he received the Ph.D. degree in 1977. He is a 1972 B.S. graduate of Baylor University in Waco.

Dr. Staiman, a scientist at the Addiction Research Foundation Clinical Institute in Toronto, Canada since 1975, will join the UMC faculty May 1. He earned the B.S., M.S. and Ph.D. degrees at the University of Toronto.

This asthmatic isn't worried about his next breath...



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Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- high theophylline for effective around-the-clock therapy
- 100% free theophylline
- individualized theophylline dosage schedule

Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.

Dosage: Initial: Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours, children 8-12: 1 tablespoonful or one capsule every 6-8 hours and children under 8: 3 to 5 mg theophylline/kg body weight every 6-8 hours. Theophylline dosage may be cautiously increased to 2000 mg/24 hr in adults or 7 mg/kg in children; monitoring of serum theophylline levels at higher dosages is recommended.

Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20μg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

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PHARMACEUTICAL DIVISION

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COMPATIBILITY

Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows

Possibly Effective

1. For the relief of symptoms associated with cerebral vascular insufficiency
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg and 20 mg
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral 10 to 20 mg three or four times daily Intramuscular 5 to 10 mg (1 or 2 mL) two or three times daily Intramuscular administration may be used initially in severe or acute conditions

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses Should not be given immediately postpartum or in the presence of arterial bleeding

Parenteral administration is not recommended in the presence of hypotension or tachycardia

Intravenous administration should not be given because of increased likelihood of side effects

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash If rash appears the drug should be discontinued

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted

Administration of single dose of 10 mg intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses For these reasons single intramuscular doses exceeding 10 mg are not recommended Repeated administration of 5 to 10 mg intramuscularly at suitable intervals may be employed

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose. Tablets, 20 mg bottles of 100, 500, 1000, 5000 and Unit Dose. Injection, 10 mg per 2 ml ampul, box of six 2 ml ampuls

U S Pat No 3,056,836

VASODILAN®
(ISOXSUPRINE HCl)
20-mg tablets

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MSMA's Big 110th Annual Session Approaches

Arrangements for the association's 110th Annual Session are moving ahead on schedule, according to the Council on Scientific Assembly which is charged with planning the annual session.

This year's meeting will be conducted April 30-May 4, at the spacious and easily accessible Coliseum Ramada Inn, Jackson.

In addition to an expanded MSMA scientific program which includes 13 scientific sections during the five day meeting, some 20 medical specialty and alumni groups are also planning meetings.

Program highlights will include a special symposium on the National Health Planning and Resources Development Act and the President's reception on Sunday, April 30. The MSMA House of Delegates will meet on Monday, May 1, and Thursday, May 4, and annual membership meetings of the Mississippi Foundation for Medical Care (PSRO) and the Mississippi Medical Fraternal and Educational Society will also be conducted during the meeting.

Social events scheduled include the MSMA fellowship party on Wednesday evening, May 3, and the second annual tennis tournament.



The Coliseum Ramada Inn of Jackson will be the host hotel for the 110th Annual Session of MSMA.

Also meeting in conjunction with the MSMA convention will be the 55th annual session of the Mississippi State Medical Association Auxiliary. Mrs. William M. Hilbun, Jr., of Tupelo is president of the auxiliary and Mrs. George S. Rowlett, Jr., of Vicksburg is president-elect.

For more information regarding the convention write Council on Scientific Assembly, MSMA, Box 5229, Jackson, MS 39216. The complete annual session program will be published in the April issue of JOURNAL MSMA.

Mississippi Is Critical Shortage Area

Almost the entire state of Mississippi will be designated as having a physician shortage under new criteria proposed by HEW to administer the National Health Service Corps and related federal programs.

Previously a critical shortage level was reached when there were 4,000 or more people per primary care physician. The new criteria lowers the level to 3,500 or more per physician and even lower levels may be designated if indicators of need such as infant mortality, health status of population and access to health services, are considered significantly adverse.

The National Health Service Corps, which is administered by the U. S. Public Health Service, is composed of physicians, nurses and other health professionals who are either volunteers or obligated to serve in the corps in repayment of a federal scholarship to obtain their training.

Central Orthopaedic Chapter Meets

The Central Mississippi Chapter, Mississippi Orthopaedic Society, met on Monday, Jan. 16 at Primos Northgate Restaurant in Jackson. The featured speaker for the meeting was William Warner, M.D., who presented a talk on Surgical Stabilization of Difficult Navicular Fractures.

Officers were elected for the 1978 year. Elected president was George W. Wharton, M.D., and Bobby Spell, M.D. was elected secretary-treasurer.

Mississippi Participates in Diabetes Control Project

On July 12, 1977, the Mississippi State Board of Health submitted a Community Diabetes Mellitus Control Demonstration Project Proposal in response to the HEW/CDC Request for proposals. Twenty-nine states submitted proposals, and Mississippi was one of the 10 states selected.

Phase I of this project covers a 10-month period during which the main activities include mortality and morbidity data collection, organization of a resource directory, and establishment of a Diabetes Advisory Council. During this period the project primarily involved identification of the extent of the problem of diabetes in Mississippi and location of the service providers in the state. These can then be compared to determine deficiencies of service and problem areas in Mississippi.

There are no accurate data on the incidence and prevalence of diabetes in Mississippi, and mortality data are incomplete due to the fact that diabetes is often relegated to a contributory cause of death rather than an underlying cause and therefore not recorded accurately on statistical tables. In spite of these problems, however, diabetes mellitus has ranked as the seventh leading cause of death in Mississippi since 1968. Only after the problem has been fully assessed can a practical plan of action be undertaken. As part of the project, a service plan will be susbsequently drawn up and the contract re-negotiated. The ultimate goal of the Diabetes Control Project is to lower the morbidity and mortality rates in the state.

Mr. Sam Lantz, Public Health Advisor from the Center for Disease Control, has been assigned to Mississippi to provide technical guidance and monitor the performance of the project. Dr. Laurance Clark will serve as physician consultant for the Diabetes Control Project.

Tri-State Thoracic Conference Convenes



Participants in the 22nd Annual Tri-State Thoracic Case Conference, held recently in Biloxi, include (from left) Dr. Richard T. Furr of Ocean Springs, president of the Mississippi Thoracic Society; Dr. John W. Bowlin, Tupelo; Dr. James M. Packer, Jackson; Dr. John D. Morgan, McComb; Dr. Watts R. Webb, guest consultant, professor and chairman, department of surgery, State University of New York, Syracuse; and Dr. Robert P. Henderson of Jackson. The conference, sponsored by Lung and Thoracic Associations of Alabama, Louisiana and Mississippi, is part of the continuing professional education program of the Christmas Seal voluntary health orgnization.

UMC Studies Temporal Bypass Procedure

Physicians at the University of Mississippi Medical Center are participating in an international investigation of a temporal artery bypass which shows promise in relieving ischemic brain disease.

Still in the developmental stages, the procedure is also believed to be effective in preventing major strokes.

Dr. Robert Smith, associate professor of neurosurgery, and co-investigator Dr. Armin Haerer, professor of neurology, will contribute 20 case histories this year to the study, supported by a National Institutes of Health grant. The new surgical procedure will be compared to conventional medical treatments.

The microsurgery requires a synthetic suture material half as thin as the finest human hair. The neurosurgeon re-routes a scalp vessel to the affected vessel inside the brain through a small trephine open-

ing in the skull, thus supplying the deprived site with up to 100 cc's of blood per minute.

The investigators point out that patients with carotid artery occlusion which cannot be managed with conventional surgical therapy, and those with stenosis of major intracranial arteries may benefit from the new bypass operation.

Doctor of the Day Is Honored



Dr. Edley Jones Sr., of Vicksburg, left, and Senator Ellis Bodron, chat after adjournment of the morning session of the Senate. Dr. Jones was in Jackson for MSMA's Doctor of the Day at the Legislature. Dr. Jones was introduced on the floor of the Senate by Senator Bodron and received a special ovation of thanks. Many MSMA members serve the Mississippi Legislature in this capacity every year.

Child Sex Abuse Is Not Reported

The incidence of sexual abuse in young children is not known, but more and more cases are coming to light and deaths have been reported, say Barbara Herjanic, M.D., and Ronald P. Wilbois, M.D., of Washington University Medical School, St. Louis.

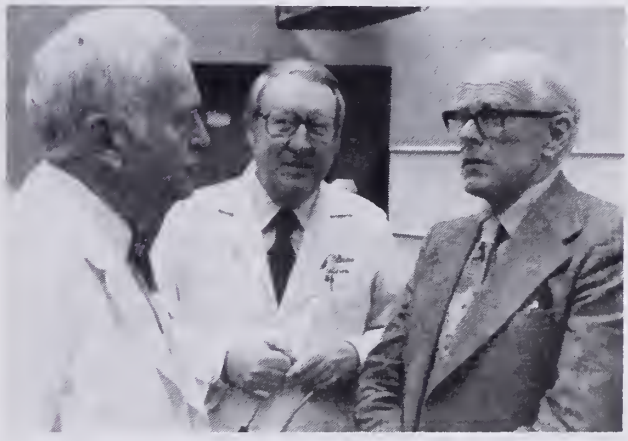
Physicians are urged to maintain a high index of suspicion of sexual abuse in their young patients. Even with a very young child, a mother may not reveal her suspicions or may deny knowledge of sexual molestation, the Missouri physicians point out.

They point to signs and symptoms that should arouse the doctors' suspicions: generalized child abuse, such as burns, bruises and unexplained fractures, discharges, lesions, painful elimination and venereal disease.

In 1975, say Drs. Herjanic and Wilbois, 132 children were treated at the St. Louis Children's Hospital for child abuse, 10 of these children were victims of sexual abuse.

Interviewing concerning possible abuse is important both in terms of making the diagnosis and in presenting evidence in court, they point out. Information must be recorded carefully, accurately and in detail. Any child old enough to talk should be interviewed separately from the parents.

Dr. Denis Burkitt Speaks at UMC



Dr. Denis Burkitt of London, right, lectured at the University of Mississippi Medical Center in January as guest of the Christian Medical Fellowship. Dr. Burkitt, who identified Burkitt's lymphoma, is also recognized for his research on bran fiber diets. His visit included medical grand rounds and a dinner for state physicians and medical students. With Dr. Burkitt are, from left, Dr. Charles Randall, UMC professor of microbiology and department chairman, and Dr. Harper Hellems, UMC professor of medicine and department chairman.

Central Medical Publishes Pictorial Directory

The Central Medical Society has published a pictorial directory of its membership and response to this initial effort has been excellent, according to Patsy B. Douglas, executive secretary.

The directory contains, in alphabetical order, a photograph of each member along with his or her address, phone number, specialty, and year and

school from which the medical degree was received.

Copies of the directory are available from the society's office, 1151 North State Street, Suite B-6, Jackson, MS 39201 for $5.00 a copy.

PSRO Cites Surgical Procedures

The American Association of Professional Standards Review Organizations has identified 11 surgical procedures which it says "have a significant potential for inappropriate utilization."

The association's national council has adopted a set of screening criteria for these procedures which will be sent to local PSROs. The surgical criteria "must not be viewed by local PSROs as mandating national standards," says the chairman of the association's Surgical Criteria Committee, John Bussman, M.D., of Portland, OR.

Rather, the local PSRO "may wish to adopt or adapt the screening criteria for local use." In a letter to the association's national council—"our committee has learned through experience and communications with PSRO's across the country, that the 11 procedures have a significant potential for inappropriate utilization," Dr. Bussman said. The 11 surgical procedures are: abdominal hysterectomy, vaginal hysterectomy, coronary arteriography, cataract removal, dilatation and curettage, tonsillectomy and adenoidectomy, cholecystectomy, hiatial hernia repair, lumbar disc excision for rupture or protrusion, meniscectomy, and appendectomy.

With respect to vaginal and abdominal hysterectomy, a subject of national attention, the national council said:

"Sterilization by abdominal (or vaginal) hysterectomy is acceptable only in the presence of concomitant uterine disease."

JCAH Urges Validation of Staff Privileges

The Joint Commission on Accreditation of Hospitals has recently emphasized in its newsletter "Perspectives on Accreditation" that current legal interpretation and court precedent clearly establish that the hospital corporation—its governing body and organized medical staff is responsible for determining the appropriateness of clinical privileges granted to individual medical staff members.

Hospitals and their medical staffs have been named as codefendants and found liable for damages in cases concerning physician competence and performance.

The JCAH states that "in view of such events, it is obviously desirable for a hospital governing board to validate (through the medical staff) a physician's appraisal of his own interests and competence within the clinical fields relevant to his hospital practice."

UMC Sponsors Gastroenterology Update

Physicians from throughout the Southeast will attend the University of Mississippi Medical Center "Gastroenterology Update" March 30-April 1.

Registrations are still being accepted for the course, planned for the Ramada Inn Coliseum in Jackson.

Dr. James L. Achord, UMC professor of medicine and director of the digestive diseases division, is course coordinator. Guest faculty are Dr. H. Worth Boyce, Jr., professor of medicine and chief of the gastroenterology section at the University of South Florida College of Medicine in Tampa; Dr. Donald O. Castell, professor of medicine at the Uniformed Services University of the Health Sciences and chief of medicine at the National Naval Medical Center in Bethesda; Dr. John T. Galambos, professor of medicine and director of the digestive diseases division at Emory University in Atlanta; Dr. Basil I. Hirschowitz, professor and director of the gastroenterology division at the University of Alabama in Birmingham; Dr. John T. Sessions, Jr., professor of medicine, Division of Digestive Diseases and Nutrition at the University of North Carolina in Chapel Hill; and Dr. Robert G. Smith, III, chief of the surgical service at the VA Hospital in Atlanta.

The UMC School of Medicine Department of Medicine Division of Digestive Diseases and the University Medical Center Division of Continuing Health Professional Education are course sponsors.

Registration fee is $150. Advance registration is required. The course meets requirements for 18 credit hours in Category I of the Physician's Recognition Award of the American Medical Association, and the American Academy of Family Physicians has approved the course for 18 credit hours.

For registration information, contact Continuing Education, University Medical Center, 2500 North State Street, Jackson, MS 39216.

MEETINGS

National and Regional

American Medical Association, Annual Convention, St. Louis, June 17-22, 1978. House of Delegates interim session, Chicago, Dec. 2-6, 1978. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

Emergency Medical-Surgical Care, Ochsner Medical Institutions, April 17-22, 1978. P. B. Johnson, Program Director, 1516 Jefferson Hwy., New Orleans, LA 70121.

Louisiana-Mississippi Ophthalmological & Otolaryngological Society, March 30-April 1, 1978, Broadwater Beach Hotel, Biloxi, MS. Ben A Davis, Jr., CAE, Executive Secretary, P. O. Box 12314, Jackson, MS 39211, telephone (601) 956-7787.

Cardiopathy of Aging IV (Heart disease in the elderly patient), Little Rock, AR, May 16-17, 1978, by the Veterans Administration, University of Arkansas College of Medicine, Council on Clinical Cardiology and Tri-State Scientific Sessions of the American Heart Association. Program Director J. E. Doherty, M.D., 300 E. Roosevelt Rd., Little Rock, AR 72206.

State and Local

Mississippi Academy of Family Physicians, Annual Meeting, July 12-15, 1978, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 110th Annual Session, May 1-4, 1978, Jackson. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Henry McCrory, Secy., P.O. Box 340, Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. G. L. Arrington, Jr., Secy., P.O. Box 4128 West Station, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1167, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Bernard Hunt, Secy., 1196 Mound St., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. James M. Cooper, Secy., 605 Garfield St., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. George Walker, Secy., 102 W. Lampkin St., Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. D. W. Lamppin, Secy., P.O. Drawer J, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Clyde Allen, Secy., 1245 N. 6th Ave., Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the individual institution or organization.

Mississippi State Medical Association
Council on Scientific Assembly
Box 5229
Jackson, MS 39216
Charles L. Mathews, Executive Director

Mississippi Urological Association
118 Broad Avenue
Gulfport, MS 39501
Ronald L. Brown, M.D., Secretary

Mississippi Radiological Society
University Medical Center
2500 North State Street
Jackson, MS 39216
John Y. Gibson, M.D., Secretary

Mississippi Chapter, American College of Surgeons
The Street Clinic
Vicksburg, MS 39180
W. Briggs Hopson, M.D., Secretary

Mercy Regional Medical Center
Vicksburg, MS 39180
John R. Shell, M.D., Chairman, Medical Education Committee

Mississippi Baptist Medical Center
1225 North State Street
Jackson, MS 39201
John F. Busey, M.D., Director of Medical Education

Delta Medical Center
1400 E. Union Street
Greenville, MS 38701
W. C. Yarbrough, M.D., Chairman, Medical Education Committee

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614
Glenn Wegener, M.D., Chairman, Medical Education Committee

Mississippi State Medical Auxiliary Association

As President of the Mississippi State Medical Association Auxiliary, it is my pleasure to give you a "State of the Auxiliary" report.

Thus far this year on the state level we have:

—Intensified our efforts to increase membership. (National dues $7.00, state dues $5.00, payable to Mrs. Doyle Smith, 1315 Simwood Place, Jackson, MS 39211, or may be paid to MSMA office.) All spouses of MSMA members are eligible.

—Located a permanent home for our museum collection of old medical instruments and books at The Natchez Museum, officially opening for the first time during Natchez Pilgrimage, March 1978.

—Enlarged Distaff, our state publication, to three issues a year. We are grateful to MSMA for their generous additional allowance of $500.00 which made this possible.

—Funded a Nurses Loan Scholarship to Ms. Marie Crispin, R.N. for further study in the field of psychiatric nursing.

—Filled hygiene kits to be distributed by World Medical Relief, Inc. to disaster areas, overseas orphanages and Indian missions.

—Enjoyed a successful "Day with the Legislature," Tuesday, January 17. We toured the Capitol, visited with individual Senators and Representatives, met with Gov. Cliff Finch and entertained Lt. Gov. Evelyn Gandy as luncheon speaker.

—Publicized medical legislative information—particularly information to legislators advising them of the danger to public health if non-medical practitioners are allowed to use drugs in the human eye.

Participated in "Immunization Initiative" by assisting the AMA in the "Schoolyard Hopscotch" project encouraging children to immunize against seven major childhood diseases—polio, measles, mumps, rubella, diphtheria, pertussis and tetanus. As a result of our involvement with this project, we have been designated by the National League for Nursing as the lead volunteer organization in Mississippi to promote immunization of Mississippi's children.

—Sent representatives to national meetings in Chicago, Dallas and Atlanta. We will send delegates to the AMA Auxiliary meeting in St. Louis, June 18-21.

We are looking forward to meeting concurrently with you at Annual Session in Jackson, May 1-3, at the Coliseum Ramada Inn. All of you are cordially invited to visit our Sunday Afternoon Welcome Booth—Sunday, April 30, 2:00-6:00 P.M. and to participate in Auxiliary social functions with us.

Thank you again for letting us share the life of medicine with you. See you at Convention.

LUCY HILBUN
President, MSMA Auxiliary

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TODAY

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Session Program in
The April Issue
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Index to Advertisers

Air Force ... 15
AMI/Eastern Region ... 19
Biloxi Health and Social Services ... 19
Burroughs Wellcome Co. ... 48A
Canton Exchange Bank ... 10
Coca-Cola ... 10
Doctors Needed ... 11
Harreld Chevrolet-Oldsmobile ... 11
Hill Crest Hospital ... 16
Eli Lilly and Co. ... 12
Mead Johnson Laboratories ... 56A, 56B
Merck Sharp and Dohme ... 7, 8
Miss. Stationery Co. ... 49
New Orleans Graduate Medical Assembly ... 6
Parke Davis and Co. ... 18
Pennwalt Corp. ... 14B, 14C
Premier Printing Co. ... 49
Riverside Hospital ... 4
Roche Laboratories ... second, third and fourth covers
Roerig and Co. ... 14, 14A
Smith Kline and French ... 48B
E. R. Squibb and Sons ... 10A, 10B
The Upjohn Co. ... 14D
Warren-Teed Pharm., Inc. ... 17
Thomas Yates and Co. ... 3

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IN CONCLUSION

Those famous Califano "Roadshows on National Health Insurance" conducted in Mississippi and other states last Fall have reached a perhaps embarrassing conclusion for their sponsors. The public is opposed to an all government health care program. A recent Harris Poll found the same reaction. All of this indicates an uphill fight on the part of NHI sponsors to drum up sufficient public support to move Congress forward on NHI. NHI appears now to be an idea whose time has come--and gone.

Mississippi Congressman Jamie Whitten will become chairman of the powerful House Appropriations Committee if he is re-elected as expected this Fall. Present chairman of the committee, George McMahon of Texas, has announced his retirement and Whitten now serves as number two man on the committee. Whitten represents Mississippi's 1st Congressional District which stretches across North Mississippi. He was elected to Congress in 1941 and for the past several years has served as chairman of Appropriations' subcommittee on agriculture.

The AMA has called for a national policy toward the aged that will keep them out of institutions as long as possible, keep them working and contributing to society, and maximize their continued independence. Recent surveys have proved that it is a myth that the aged are, as a group, fragile, isolated and despairing. The medical profession strongly encourages the development of expanded home health care services, including both the strictly health-care segments of that program and the more general homemakers' and meals-on-wheels type of service.

Dx and Rx: A Physician's Guide to Medical Writing, a practical manual written specifically for all physicians who want to write for publication, is available now from G. K. Hall & Co. The book, by John H. Dirckx, M.D., author of The Language of Medicine, shows physicians how to improve the accuracy, clarity, and readability of their writing. It is the first technical writing manual to emphasize the composition of sentences and to offer specific advice on what to do and what not to do with words.

Insurance Economics Surveys reports one "you want believe." "A foreigner who is age 65 or older, or younger if disabled, can come to the United States and after 30 days start receiving a lifetime government pension of up to $295 a month...plus Medicare." Meanwhile, Congress is receiving increased criticism for Social Security Tax increase last year which will triple the maximum tax over the next decade. Latest move appears to be to drop Medicare and Disability funding from Social Security and fund with general tax revenues. 1959 maximum SS tax was $60. 1987 will be $6,091.80.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children.* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.



ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



This is a source of somatic symptoms of anxiety.



And this is a source of relief...

VALIUM® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

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Please see the preceding page for a summary of product information.

Artist's symbolic conception of a CNS rea[illegible] excessive stress in the overanxious patient [illegible] somatic symptoms of the gastrointestinal [illegible] systems. Special photographic [illegible] applied to a model of the brain.

April 1978

BALCONY

Journal of the State Medical Association

Mississippi



Contents:

Meckel's Diverticulum

Complete Program of MSMA's 110th Annual Session

ACNE'S ANXIETY





BENZAGEL® 5% Acne Gel 10% Acne Gel

(5% or 10% benzoyl peroxide, 6% polyoxyethylene lauryl ether, 40% alcohol)

Early visible improvement helps to relieve anxiety and promotes patient cooperation—Simple and pleasant to use

- Benzoyl peroxide in a special alcohol gel base—Reliable and predictable, imparts a pleasant cooling sensation with controlled drying of sebaceous oils. Accelerates desquamation.
- "BP base/bond" for uniform therapeutic deposition of benzoyl peroxide—Reduces burning sensation on application, for greater patient acceptance.
- Effective antibacterial and comedolytic action—Rapid improvement is seen, often within two weeks

BENZAGEL® a basic component of acne therapy

Description: 5% or 10% benzoyl peroxide, 6% polyoxyethylene lauryl ether and 40% alcohol in an astringent gel containing colloidal magnesium aluminum silicate, hydroxypropyl methylcellulose, citric acid, fragrance and purified water

Action: Provides drying, desquamative and antiseptic activity

Indication: An aid in the treatment of acne

Dosage and Administration: Wash affected areas prior to application. Apply once or more daily or as directed by physician

Contraindications: Should not be used by patients having known sensitivity to either benzoyl peroxide or polyoxyethylene lauryl ether

Precautions: For External Use Only. Not for ophthalmic use. Keep away from eyes and mucosae. Very fair individuals should begin with a single application at bedtime allowing overnight medication. May bleach colored fabrics. Keep this and all other medications out of the reach of children

Caution: Federal law prohibits dispensing without prescription

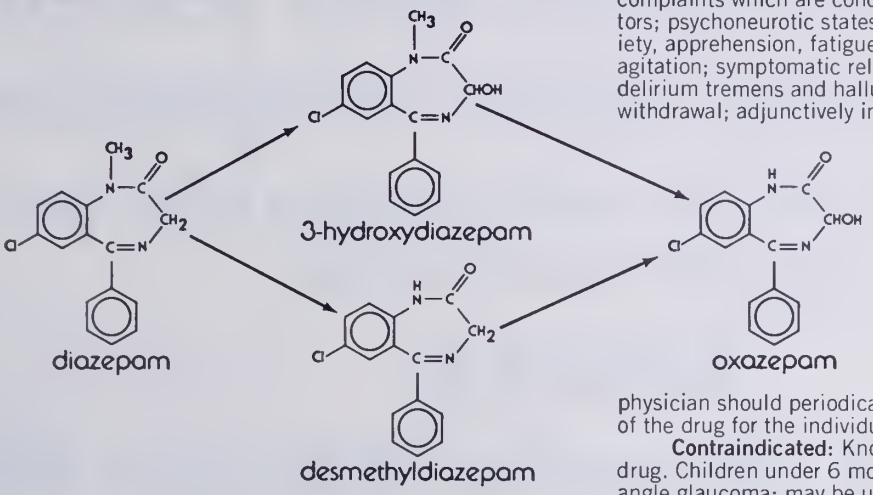
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Fort Washington, Pa. U.S.A. 19034

A pharmacokinetic character all its own



Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

The pharmacokinetic profile of Valium is one of the characteristics that sets it apart from other benzodiazepines. Consider, in particular, the metabolic pathway of Valium. The three major metabolites of Valium exhibit significant pharmacologic activity—and so, of course, does the parent substance—diazepam itself. All combine to produce the characteristic clinical response seen with Valium. The response you have come to know, to want and to trust.

Pharmacokinetic studies also demonstrate that Valium has a pattern of absorption, distribution, metabolism and elimination that is reliable and consistent. And, although the pharmacokinetics of a drug cannot, at present, be specifically related to its clinical effects, it is clearly a factor that distinguishes one product from another by providing important insights into how each moves through the patient's body.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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There are any number of excellent reasons why you need extra money when hospitalized.

And that's all the more reason why you should enroll in the

MSMA Sponsored Hospital Money Plan®

- Benefits of up to $100 per day for hospitalization due to a covered accident or sickness.
- Benefits of up to $200 per day for admittance to an intensive care unit; or for cancer or leukemia, including metastatic tumors.
- Benefits of up to $50 per day for confinement in a convalescent care facility.
- Benefits payable directly to you (unless assigned) in addition to any other insurance you may have.

AND ACCEPTANCE IS GUARANTEED for you, your spouse and eligible, unmarried dependent children.

With hospital costs at an all time high, there is an urgent need for extra protection – beyond your basic hospital policy. And you can get this vital protection regardless of your past or present health history! Even if you've been refused coverage elsewhere! Because acceptance is guaranteed for you, your spouse, and all eligible, unmarried dependent children under this officially-sponsored Mississippi State Medical Association's HOSPITAL MONEY PLAN.*

It can help protect your financial security by providing daily benefits up to $100 a day – payable directly to you, unless otherwise assigned, with double benefits payable for confinement in an Intensive Care Unit or for treatment of cancer. Daily convalescent care benefits of up to $50 a day are also provided along with optional surgical benefits.

Best of all, this high benefit, low-cost supplemental protection can be **renewable to MSMA members, regardless of age.**

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Volume XIX
Number 4
April 1978



JOURNAL of the Mississippi STATE MEDICAL ASSOCIATION

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CONTENTS

ORIGINAL PAPER

Radiologic Seminar CLXXX: Meckel's Diverticulum **63** OTTIS G. BALL, M.D., Jackson, MS

SPECIAL FEATURE

MSMA 110th Annual Session **65** Complete Program

EDITORIAL

Microsurgery—An Expanding Field **79** Myron W. Lockey, M.D., Jackson, MS

THIS MONTH

The President Speaking **78** "Are We Giving It Away?"

Medical Organization **85** MSMA Board of Trustees Meets in Jackson

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Riverside.

Mississippi's Unique Psychiatric Hospital.

Riverside Hospital is unique in Mississippi.

As a privately owned 56-bed short term care facility for treating patients with psychiatric illness or emotional problems, it is the only hospital of its kind in the state.

Architecturally designed to create an attractive open environment, Riverside's "non-institutional" atmosphere helps prepare the patient for specific therapy, healthy entertainment and physical recreation.

The clinical program incorporates a wide range of modern psychiatric ideas. Emphasis is placed on interpersonal relationships, small group functions, and professional individualized care.

The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

For additional information contact: John R. Reedy, Executive Director.



Riverside Hospital

P.O. Box 4297, Jackson, MS 39216
Telephone: (601) 939-9030

AOA Lecturer Visits Medical Center

The head of pediatrics at the University of North Carolina School of Medicine in Chapel Hill was at the University of Mississippi Medical Center Feb. 6-10 as Alpha Omega Alpha lecturer.

Dr. Floyd W. Denny addressed the UMC center assembly on "the compleat physician and the future of medicine" and presented grand rounds in surgery, medicine and pediatrics.

The South Carolina native accepted the North Carolina post in 1960. He was a visiting worker on the Medical Research Council of the Clinical Research Center in London from 1970-1971.

He is a B.S. graduate of Wofford College in South Carolina and earned the M.D. degree at Vanderbilt University in 1946. Dr. Denny interned and took residency training at Vanderbilt University Hospital. He was a research fellow at Western Reserve University in Cleveland, Ohio.

A Phi Beta Kappa and AOA member, Dr. Denny serves on the editorial board of *Journal of Pediatrics*, and is a past editorial board member of the *American Review of Respiratory Diseases*. He is recorder for the American Pediatric Society. Dr. Denny was among recipients of a Lasker Award presented to the Armed Forces Streptococcal Disease Laboratory Group at the 1954 American Public Health Association meeting for contributions to medicine.

New Medicare Payment List Prepared

At the direction of the government, health insurance carriers have mailed letters to the nation's physicians listing their total dollar Medicare business last year. Physicians have 30 days in which to review the figures and return them to the carrier with comments or changes.

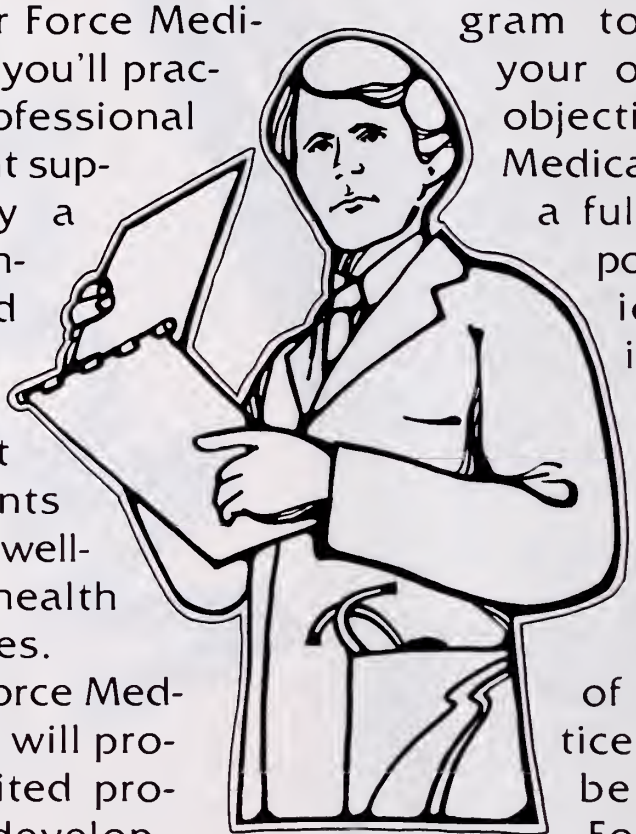
The totals for all physicians will be available to the public at the offices of the carriers, the regional offices of HEW, and at Medicare's main office in Baltimore, MD.

The compilation is a follow-up of the decision by HEW last year to publish the names of physicians who did more than $100,000 a year in Medicare business. HEW Secretary Joseph Califano said the "sunshine" laws regarding public scrutiny of federal operations required public disclosure.

Under the new approach now being carried out, there is no $100,000 cut-off. All Medicare total payments to physicians for the previous calendar year will be open to those seeking the specific information.



Physicians: we treat you seriously in the Air Force



As an Air Force Medical Officer, you'll practice in a professional environment supported by a team of highly qualified technical assistants. You'll treat your patients in modern, well-equipped health care facilities.

The Air Force Medical Service will provide unlimited professional development, with a carefully designed individual program to complement your own skills and objectives. Air Force Medical Centers offer a full range of opportunities in clinical medicine, including clinical investigation.

Avoid the time consuming burdens of private practice. Consider the benefits of Air Force medicine. Health care at its very best.

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Air Force. A great way of life.

NEWSLETTER

April 1978

Dear Doctor:

Mississippi pharmacists are starting a drive to emphasize the value of child resistant containers in preventing accidental poisonings. The publicity campaign will be conducted by the Bureau of Pharmaceutical Services at the University of Mississippi in conjunction with the Mississippi Pharmaceutical Association and funded by the U.S. Consumer Product Safety Commission. One of the biggest aims of the program is to alert parents to the dangers of accidental poisonings.

> The small amount of inconvenience of safety caps is a low price to pay for saving a child's life, say the pharmacists who recommend poison prevention packaging unless the patient suffers from a physical handicap. Prevention 365 days a year is the best solution to accidental poisonings.

Consumers account for 53.1% of the membership on health systems agencies (HSAs) governing boards, according to a recent HEW survey. In Mississippi, the board of the Mississippi Health Systems Agency, Inc. (MHSA) is composed of 52.8% consumers. Of 204 HSAs in the survey, 81 were new agencies such as MHSA, 113 were former Comprehensive Health Planning Agencies and 10 were RMPs or other designated agencies.

In what the author cites as "not necessarily conclusive findings," BC-BS of Greater New York found that physicians giving second opinions for non-emergency surgery turned down one of every four cases recommended by first doctor. Preliminary findings are based on 1,500 cases. Blues state economic impact of study would indicate that second opinion program would save $700,000 in hospital and medical costs in two years.

The Health Insurance Institute reports that the average length of stay in a hospital was the same in 1976 as it was in 1975--7.7 days. However, the cost of care to a community hospital for an average stay went from $1,164 in 1975 to $1,330 or more than 14% increase in 1976. The average hospital per diem went from $151 to $173 in 1976.

About 1,000 comments were received on revised "National Health Planning Guidelines" issued by HEW Secretary Califano after original guidelines drew over 50,000 comments and resolutions from Congress critical of their potential impact on hospital beds and services. House subcommittee recommended an amendment be added to P.L. 93-641 specifically stating that guidelines are not directives to local planning agencies.

Sincerely,

Nola Gibson
Managing Editor

Analysis Blasts SS Tax Boosts

The massive Social Security tax increases over the next decade will be as painful to the economy collectively as they will be to workers and employers individually, according to an unpubished congressional staff analysis.

The tax increases, which Congress overwhelmingly approved last year and President Carter lauded as "wise," will cost 1.3 million workers their jobs and add significantly to inflation, the study says.

. . . "The Social Security bill will ensure the long-run financial integrity of the Social Security system only under reasonably favorable economic and demographic conditions," the study by the staff of Congress' Joint Economic Committee asserts. "Protracted economic stagnation, slow growth of productivity, continuing rapid inflation and a decline in the fertility rate below present expectations could put the Social Security system into long-run deficit despite the measure that has been passed by Congress."

The analysis stands as the strongest indictment yet of Congress' decision in December to as much as triple Social Security taxes on middle and high-income workers and their employers to save the retirement program from bankruptcy.

The study is unusual because it is rare for a congressional committee staff to so strongly criticize an act of Congress—particularly when the issue is as explosive as Social Security and an election is less than nine months away.

Laetrile Suit Is Successful

In what was believed to be the first medical malpractice trial in the United States stemming from a doctor's use of the controversial cancer treatment laetrile, a federal court jury in Atlanta has awarded $15,000 damages to the widow of an Alabama man who died after being treated with laetrile by Rep. Lawrence P. McDonald (D-Ga.).

McDonald, 42, a practicing urologist before his election to Congress in 1974, said he would appeal.

Following an emotional and sometimes tumultuous three-week trial which had both medical and political overtones, the six-member jury ordered McDonald to pay damages only for the "medical and other expenses attendant upon the last illness" of the laetrile patient.

The jury rejected plaintiff's request for damages for "pain and suffering" and for possibly shortening the cancer patient's life.

"It didn't do any good, but it didn't cause his death," said juror Chris Boyes, describing the panel's attitude toward laetrile.

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

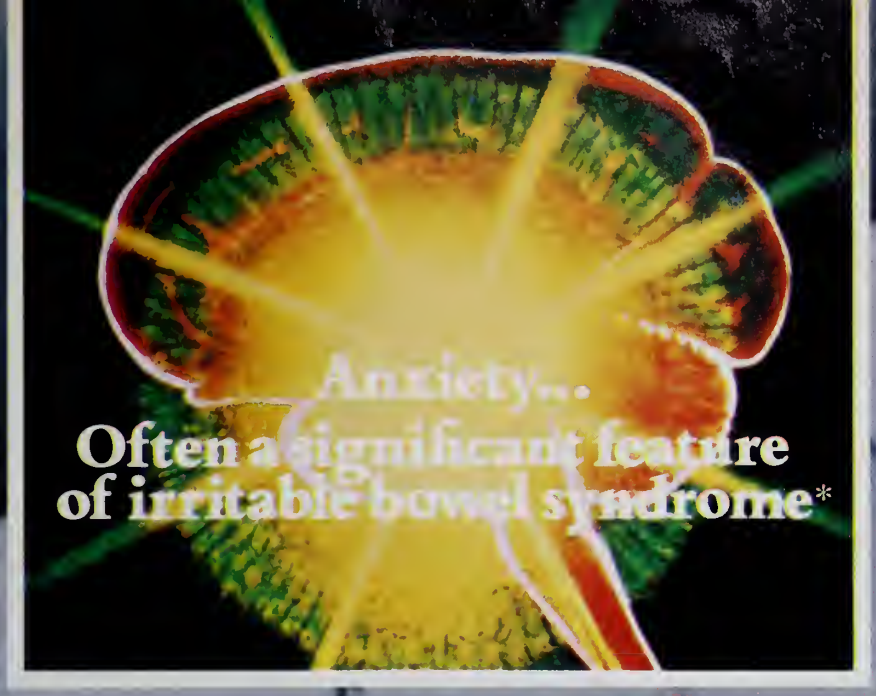
As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema; minor menstrual irregularities; nausea and constipation; extrapyramidal symptoms; increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis); jaundice; hepatic dysfunction reported occasionally with chlordiazepoxide HCl; making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701



The action of Librium®
(chlordiazepoxide HCl)

A significant advantage of adjunctive

Librax®

Each capsule contains
5 mg chlordiazepoxide HCl and
2.5 mg clidinium Br.

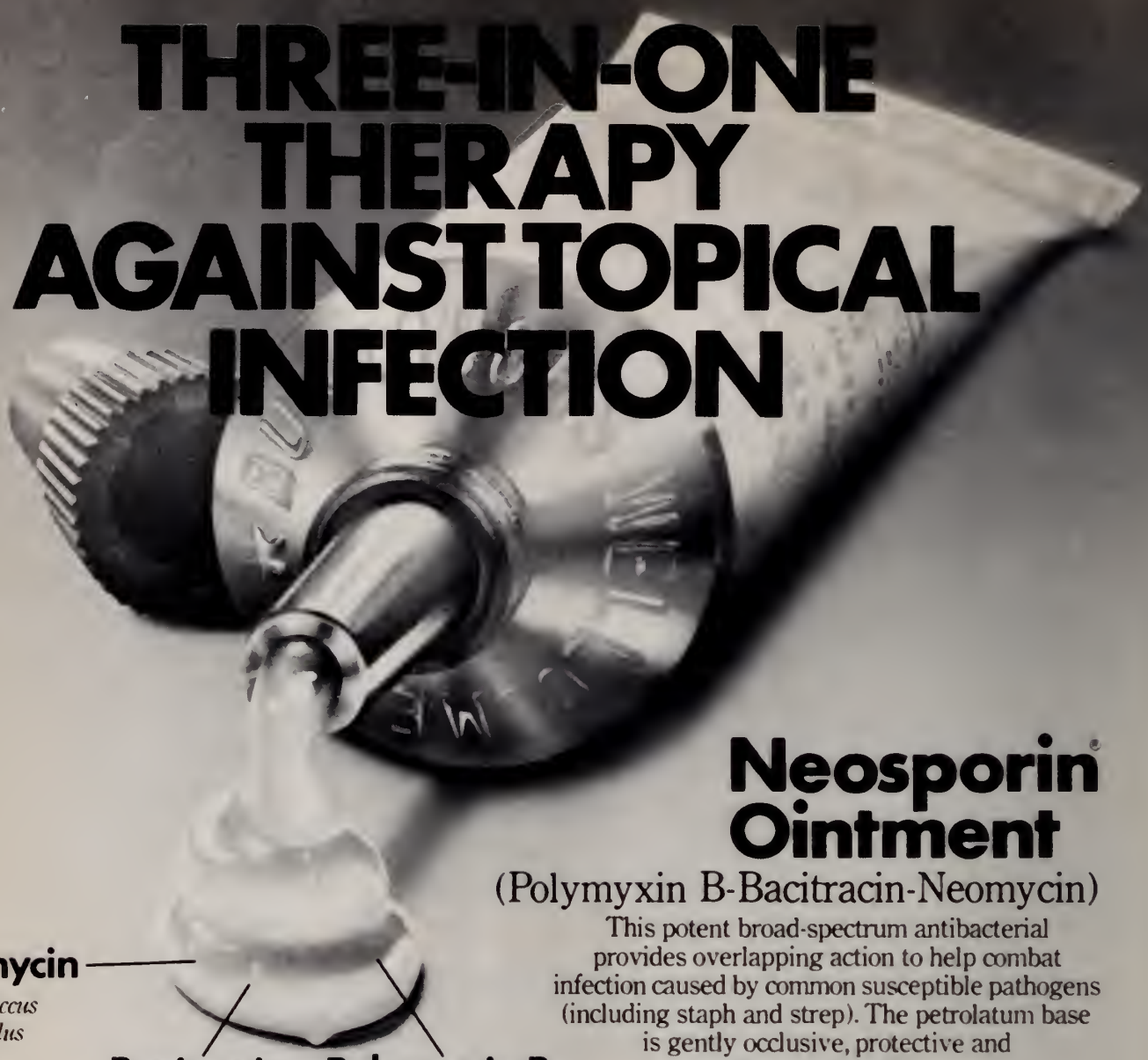
Antianxiety
Antisecretory
Antispasmodic

Librax is unique among G.I. medications in providing the specific antianxiety action of Librium® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of Quarzan® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.*

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.

ROCHE

THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin
Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin
Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B
Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units, zinc bacitracin 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base), special white petrolatum qs, in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching, it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

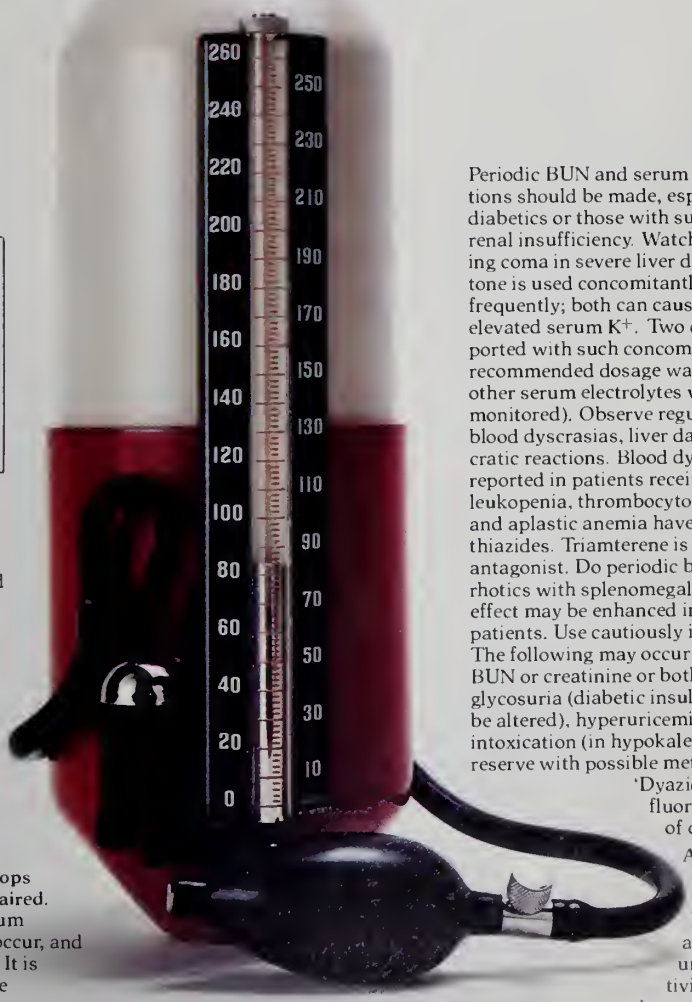
Complete literature available on request from Professional Services Dept. PML.

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION:* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

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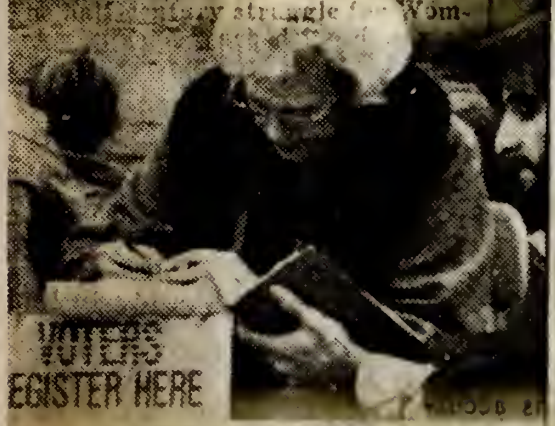
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MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Joble

Roosevelt Approves Message Intended to Benefit 30,000,(Persons When States Adopt Cooperating Laws-He Cal the Measure 'Cornerstone' of His Economic Program.

WASHINGTON, Aug. 14, 1 The Social Security Bill, provi a broad program of unemploy insurance and old age pens and counted upon to benefit 20,000,000 persons, became la day when it was signed by P dent Roosevelt in the presen those chiefly responsible for ting it through C s.

Mr. Roosevelt cal me "the cor erstone str which is ein m

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sen

COM

UL IGNE

the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary sessio

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

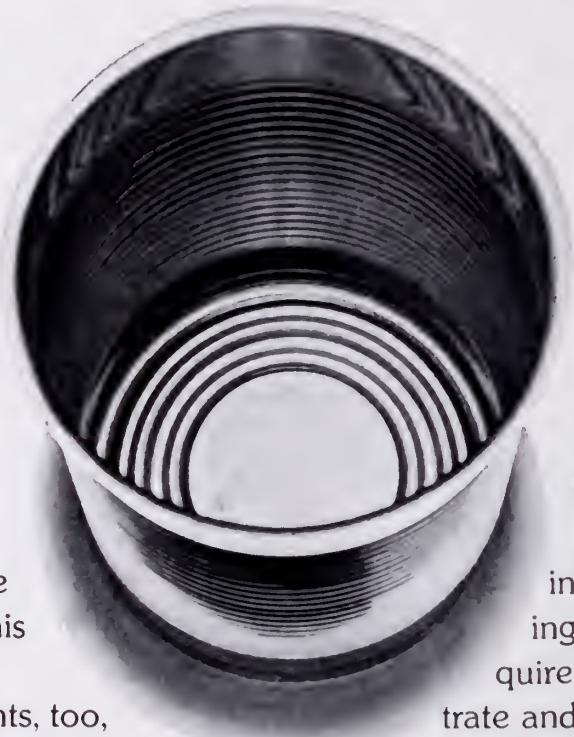
The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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DATELINE

Document Patient's Noncompliance

St. Paul, MN - Physicians are familiar with patients who ignore doctor's orders and proceed with forbidden behavior. Noncompliant patient is subject to health complications, perhaps death. If patient's condition degenerates because he disregards his physician's counsel, physician may be found wholly or at least partially blameless. The best way to prevent malpractice suits or strengthen doctor's defense is by routine documentation of compliance-noncompliance during course of treatment.

Laetrile Users Should Watch Diets

Chicago, IL - Cancer patients who are taking laetrile should select carefully the foods they eat, University of California researchers warn in JAMA. Failure to do so could be fatal. Many popular fruits and vegetables contain chemicals called hydrolytic enzymes. Laetrile is chemically a cyanogenic glycoside. When C. glycosides come in contact with foods containing hydrolytic enzymes, the resulting mixture is hydrogen cyanide, a deadly poison which acts quickly.

Film Emphasizes Immunizations

Evanston, IL - "A Gift, An Obligation," an American Academy of Pediatrics' film stressing the importance of childhood immunizations, is now being distributed to television stations across the country. The film was produced by the academy with grant assistance from Merck, Sharp and Dohme. The half-hour color film uses vignetts to remind audiences of the often tragic consequences of such diseases as whooping cough, measles, diphtheria, mumps and polio.

Social Security Will Be Reviewed

Washington, DC - HEW Secretary Califano has announced the appointment of an Advisory Council on Social Security to conduct a comprehensive review of the social security program. He asked that the council "pay particular and prompt attention to the methods and goals of financing the trust funds." The trust funds will be reviewed in terms of their scope of coverage, adequacy of benefits, and all other aspects of the program including impact on public assistance programs.

Antitrust Suit Filed Against Medical Society

Cincinnati, OH - Ohio's Attorney General's Office has filed an antitrust suit against the Mahoning County Medical Society (Ohio), among others, alleging a conspiracy to keep an HMO from going into business. The case is expected to have important implications for Health Maintenance Organizations around the country where organized physician opposition has been alleged in several areas as a major obstacle to HMO development.

What Was MSMA Worried About in 1878?

With the 1978 annual session of the association approaching, it seems appropriate to reflect on what physicians in the state were concerned about when they met in 1878.

Dr. B. F. Kitrell of Black Hawk became MSMA president at the 1878 annual session. He was a leader in establishing the Mississippi State Board of Health and pushed passage of the Medical Practice Act.

And what were the physician delegates to the MSMA House of Delegates concerned about in 1878? According to official records of the association, they were concerned about the failure of their efforts in the 1877 legislature to establish a strong public health program and medical licensure act. "The law (State Board of Health) is worthless" they said. Perhaps, prophetically, later in 1878 some 20 MSMA members or 10 per cent of the membership died during what became known as the "great yellow fever epidemic."

MMFES Will Hold First Meeting

The first annual membership meeting of the Mississippi Medical Fraternal and Educational Society will be held beginning at 3:00 p.m., Sunday, April 30, at the Coliseum Ramada Inn in Jackson in conjunction with MSMA's 110th Annual Session.

Dr. Faser Triplett, president of the society, stated that "the society will sponsor a special presentation on the malpractice risk management program developed by the Colorado Medical Society to which all physicians are invited and conduct elections for board members."

The Mississippi Medical Fraternal and Educational Society was established by action of the MSMA House of Delegates at a special session in October 1975 called in response to the then developing professional liability insurance crisis. The society began issuing professional liability insurance policies last December and now has some 800 members. Notification of the first annual meeting has been mailed to all MMFES members.

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Indication: Povan is indicated for the treatment of enterobiasis.

Warnings: No animal or human reproduction studies have been performed. Therefore, the use of this drug during pregnancy requires that the potential benefits be weighed against its possible hazards to the mother and fetus.

Precautions: To forestall undue concern and help avoid accidental staining, patients and parents should be advised of the staining properties of Povan. Care should be exercised not to spill the suspension because it will stain most materials. Tablets should be swallowed whole to avoid staining of teeth. Parents and patients should be informed that pyrvinium pamoate will color the stool a bright red. This is not harmful to the patient. If emesis occurs, the vomitus will probably be colored red and will stain most materials.

Adverse Reactions: Nausea, vomiting, cramping, diarrhea, and hypersensitivity reactions (photosensitization and other allergic reactions) have been reported. The gastrointestinal reactions occur more often in older children and adults who have received large doses. Emesis is more frequently seen with Povan Suspension than with Povan Filmseals.

How Supplied: Each Povan Filmseal® contains pyrvinium pamoate equivalent to 50 mg pyrvinium, supplied in bottles of 50 (NDC 0710-0747-50; NSN 6505-00-134-1966). Povan Suspension, a pleasant-tasting, strawberry-flavored preparation containing pyrvinium pamoate equivalent to 10 mg pyrvinium per milliliter, is supplied in 2-oz bottles (NDC 0071-1254-31; NSN 6505-00-890-1093).

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House of Delegates Has Full Agenda

MSMA's House of Delegates will have a full agenda of reports and policy recommendations to consider when the delegates convene in Jackson on May 1 at the Coliseum Ramada Inn.

Before the delegates will be reports concerning endorsement of Blue Cross-Blue Shield of Mississippi, enactment of a continuing medical education program as a condition of membership in the association, Medicare and Medicaid reimbursement policies, seating of UMC housestaff delegates, approval of an interprofessional code between Mississippi physicians and attorneys, establishment of an association-sponsored rehabilitation program for the disabled physician, sponsorship of a public opinion poll on health care in Mississippi and other ongoing association matters.

Following the format begun at last year's meeting, all reports will be mailed to delegates two weeks prior to the meeting and the agenda for the opening session of the House of Delegates at 9:30 a.m., Monday, May 1, will consist of the address of the president, introduction and remarks of distinguished guests, organization of committees of the House and introduction of resolutions. Reference committees of the House will meet Monday afternoon.

DOCTORS NEEDED

To perform consultative examinations for Disability Determination Services (a State Agency).

These examinations can be done in your office and will be used to determine if disability applicants meet the definition of disability under the Social Security Act.

Specialties needed:

Internists, Neurosurgeons, Neurologists, Psychiatrists, Orthopedists, Ophthalmologists, Pediatricians, and Otolaryngologists.

Also needed:

Family Practitioners and General Practitioners who are equipped to perform comprehensive medical examinations.

Payment is usually on a customary fee basis for both consultation and laboratory fees.

For more information, call or write:

Ed Adams
Professional Relations Officer
Disability Determination Services
P. O. Box 1271
Jackson, MS 39205

Phone: 1-800-222-8325 (toll free)
If in Jackson: 969-6811

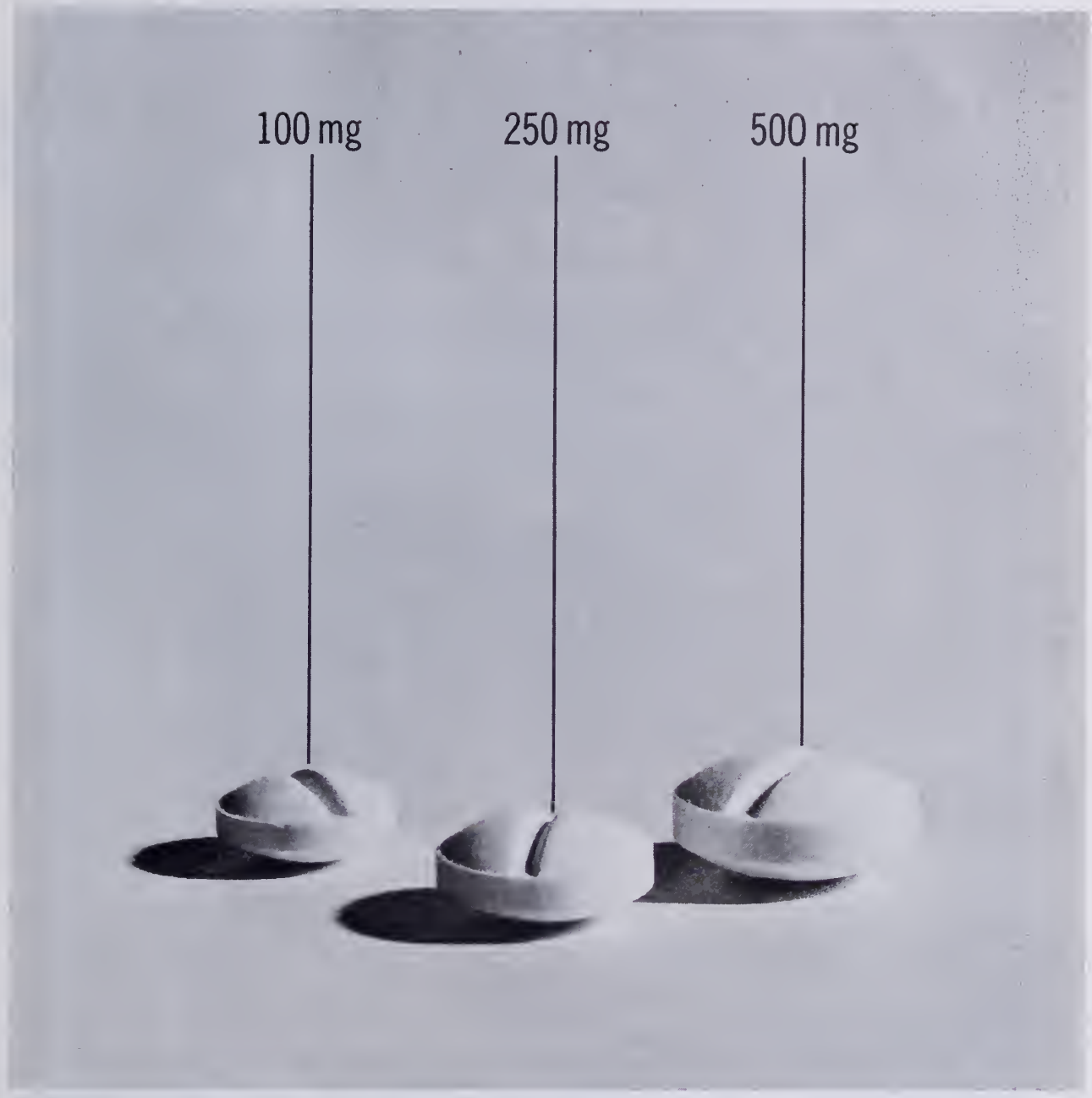
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110th Annual Session of MSMA

April 30-May 4, 1978

Coliseum Ramada, Jackson

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
April 1978, Vol. XIX, No. 4

ORIGINAL PAPERS

Radiologic Seminar CLXXX: Meckel's Diverticulum

OTTIS G. BALL, M.D.
Jackson, Mississippi

AN INFLAMED or bleeding Meckel's diverticulum may pose a serious diagnostic problem for the pediatricians and surgeons.

A Meckel's diverticulum represents the vestigial remnant of the omphalomesenteric duct and is usually located within about 12 inches of the ileocecal valve. However, it may be located 2 to 3 feet proximal to the valve.

Approximately 1.5 per cent of the population have a Meckel's diverticulum and 55 per cent of these contain gastric mucosa.

Plain films of the abdomen reveal no specific abnormality in the case of a bleeding Meckel's diverticulum, and it may be quite difficult to demonstrate on barium studies. Abdominal scans, after the intravenous injection of ^{99m}Tc Pertechnetate, have been used to detect diverticula containing gastric mucosa. The ^{99m}Tc Pertechnetate concentrates in the parietal cells of the gastric mucosa and then is secreted into the bowel lumen.

The abdominal scans should be performed during fasting. A Levin tube in the stomach is helpful to prevent confusing foci appearing in the upper small bowel due to emptying of the stomach secretions. However, no premedication or other patient preparation is required. Serial anterior images are obtained with the scintillation camera at 5, 10, 20, 30 and 60 minutes. The stomach and urinary bladder areas should be included for comparison of activity. Delayed images may sometimes be helpful. When ectopic activity similar in intensity to that in the stomach is seen, the diagnosis can be made with fairly good assurance.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Mississippi Baptist Medical Center, Jackson, MS.

Case Report

A five-year-old child was admitted to the hospital with rectal bleeding, nausea, vomiting and fever. Considered in the differential diagnosis were: intussusception, Meckel's diverticulum, colon polyp, peptic ulcer disease and possibly some type of blood dyscrasia. However, the blood studies were normal

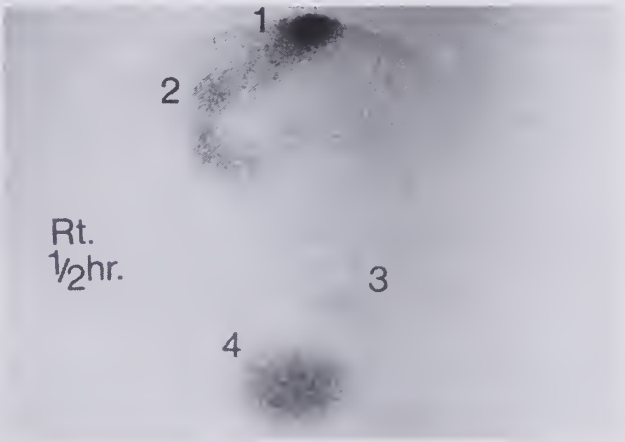


Figure 1. ^{99m}Tc Pertechnetate Abdominal Scan: Anterior image performed with the scintillation camera at 30 minutes. Note activity above the bladder in the Meckel's diverticulum which is about as dense as that in the antrum of the stomach. Legend: 1. Stomach, 2. Duodenum, 3. Meckel's diverticulum, 4. Urinary bladder.

except for anemia. The proctoscopic examination and barium enema study revealed no abnormality. The Upper GI series and small bowel study were thought to be normal.

The ^{99m}Te Pertechnetate abdominal scan indicated an abnormal focus of activity in the left lower quadrant of the abdomen thought to be consistent with a Meckel's diverticulum. Surgery was performed with removal of a Meckel's diverticulum which measured 2 cm. in size. Histologic study revealed the diverticulum to be lined with ectopic gastric mucosa. A 0.5 cm. area of mucosal ulceration was noted to be present. ★★★

1225 N. State Street (39205)

References

1. James, A. D., Wagner, H. N., and Cooke, R. E.: *Pediatric Nuclear Medicine*, W. B. Saunders Co.: 298-307, 1974.
2. Rosenthall, L., Henry, I. A., Murphy, D. A., and Freeman, L. M.: Radiopertechnetate Imaging of the Meckel's Diverticulum. Radiology, 105:371-373, 1972.

Dr. Stanley Hartness of Kosciusko reports an unusual case in which a patient became pregnant with an IUD (CU-7). The patient went to full term and delivered uneventfully a full term female infant. No evidence of the IUD was apparent at delivery. The patient denied any knowledge of it having passed. At her 6 weeks postpartum check-up she requested another IUD. As the cervix was being prepared for the IUD insertion, a black string was noticed protruding from the cervical os. When this was removed, it was found to be the original CU-7. Another was inserted. Following this the patient remarked as she left the examining room, "I'd probably have been better off if he'd left 'em both in!"

—Editor

On Tuesday morning during the meeting of the Mississippi State Medical Association, the Section on Dermatology will present a program covering a wide range of diagnostic and therapeutic problems of interest and utility to all practicing physicians. This is an open meeting and all members of the Mississippi State Medical Association are invited to attend and participate.

Questions are welcome and will be helpful in preparing the format of the program. The questions may be handwritten on a prescription blank and sent to:

Section on Dermatology
Mississippi State Medical Association
430 Woodland Hills Bldg.
Jackson, MS 39216

110th Annual Session

Mississippi State Medical Association
April 30-May 4, 1978
Jackson

The progressive state capital city beckons Mississippi physicians and their families as the 110th Annual Session of the association gets underway April 30, May 1-4, 1978 at the Coliseum Ramada Inn. Thirteen scientific sections, fifteen specialty societies and related groups, three medical alumni social occasions, technical and scientific exhibits, the House of Delegates, and a host of fellowship events are slated for the five-day meet.

Dr. James O. Gilmore of Oxford, association president, will address the opening meeting of the House of Delegates on May 1. House Speaker C. D. Taylor, Jr., of Pass Christian, and Vice Speaker R. Faser Triplett of Jackson said that delegates will receive their complete House of Delegates folders before May 1 for study prior to the convention. The opening session of the house will again be limited to the address of the president, recognition and remarks of distinguished guests and introduction of reports and resolutions not received in time for inclusion in the delegates folder. Final action will come on May 4 when 1978-79 officers are also elected.

Dr. Carl G. Evers of Jackson will be inaugurated president for the new year during closing ceremonies on the final day.

Dr. J. Elmer Nix of Jackson, Council on Scientific Assembly chairman, said that the Scientific Assembly will open on Sunday morning, April 30, and continue through Wednesday afternoon, May 3. The Scientific Assembly has been approved for 15 hours of MAFP prescribed credit and 15 hours Category I credit toward the AMA Physician's Recognition Award. A special feature on Sunday afternoon will be the annual membership meeting and special program of the Mississippi Medical Fraternal and Educational Society, Inc., from 3-5:00 p.m. in the Crown Room. Dr. Nix heads the group which has planned and scheduled the general and specialty sessions, exhibits and fellowship occasions.

Principal speaker for the annual session is Dr. John H. Budd of Cleveland, OH, president of the American Medical Association. He is scheduled to address the opening meeting of the House of Delegates on May 1, Dr. Gilmore said.

The MSMA Auxiliary will conduct its 55th Annual Session concurrently during April 30-May 3, also headquartering at the Coliseum Ramada Inn, according to Mrs. William Hilbun of Tupelo, state president. Mrs. Sam Rowlett of Vicksburg will be inaugurated 1978-79 president of the auxiliary at the meeting. General chairmen are Mrs. George Arrington of Meridian, convention chairman; Mrs. Stewart Williford of Hattiesburg, registration; and Mrs. Joel Callahan and Mrs. William B. Simmons of Meridian, luncheon.

Medical alumni occasions are set for Monday evening and Ole Miss, Tulane and Tennessee have scheduled events. The annual MSMA fellowship party will feature cocktails and hors d'oeuvres leaving convention-goers on their own for dinner at one of Jackson's many excellent restaurants. Party tickets will be $6.00 per person and festivities are set for 6:00 p.m. on Wednesday, May 3. Tickets will be on sale at MSMA Registration.

Room reservations at the Coliseum Ramada Inn are being made directly with the hotel.

OFFICIAL CALL

To all members of the Mississippi
State Medical Association:

The 110th Annual Session of the Mississippi State Medical Association is called to meet at Jackson, Mississippi, on Monday, May 1, 1978, pursuant to Article V of the Constitution. The House of Delegates will be convened at 9:30 a.m. in the morning at the Coliseum Ramada Inn on May 1.

The Scientific Assembly consisting of the 13 general sessions, will meet during April 30-May 3, 1978.

No member or guest will be permitted to participate in any aspect of the annual session until regularly registered.

JAMES O. GILMORE
PRESIDENT
J. ELMER NIX
SECRETARY-TREASURER

STATE OFFICERS 1977-1978



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Stanley A. Hill, Corinth	1959-60
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Lawrence W. Long, Jackson	1961-62
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Omar Simmons, Newton	1964-65
Everett Crawford, Tylertown	1965-66
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Charles R. Jenkins, Laurel	1972-73
Arthur A. Derrick, Jr., Durant	1973-74
J. T. Davis, Corinth	1974-75
Jack A. Atkinson, Brookhaven	1975-76
Lyne S. Gamble, Greenville	1976-77

ACTIVITIES CALENDAR

REGISTRATION

General Registration for the Scientific Assembly and House of Delegates will be located in the lobby of the Coliseum Ramada Inn near the Empire Room. No person may be admitted to any activity of the annual session without first registering. **There will be a registration fee of $25.00 for nonmember physicians except interns and residents.** Hours of registration will be 10:00 a.m. to 4.00 p.m., Sunday, April 30; 8:00 a.m. to 5:00 p.m., Monday, Tuesday, and Wednesday, May 1, 2 and 3; and 8:00 to 9:00 a.m., Thursday, May 4.

SUNDAY, APRIL 30, 1978

9:00 a.m. MSMA Scientific Meeting—Section on Orthopedic Surgery, Ramada 2

9:00 a.m. MSMA Scientific Meeting—Section on Pathology, Gallery C

9:00 a.m. MSMA Scientific Meeting—Section on Anesthesiology, Ramada 4
10:00 a.m. MSMA Scientific Meeting—Section on Psychiatry, Ramada 3
12:00 noon Mississippi Orthopedic Society Luncheon, Gallery A
12:00 noon Mississippi Psychiatric Association Luncheon, Ramada 1
12:30 p.m. Mississippi Association of Pathologists Luncheon, Gallery B
3:00 p.m. Annual Membership Meeting, Mississippi Medical Fraternal and Educational Society, Inc., Crown Room
3:30 p.m. Ole Miss Guardian Society Business Meeting, Gallery A
6:00 p.m. MSMA President's Reception, Crown Room
6:00 p.m. Mississippi Society of Anesthesiologists Dinner, Gallery B
7:00 p.m. Ole Miss Guardian Society Cocktail Party and Dinner, Ramada 2-4

MONDAY, MAY 1, 1978

8:00 a.m. MSMA Reference Committee Breakfast, Gallery B
9:00 a.m. Mississippi Society of Anesthesiologists Brunch, Ramada 1
9:30 a.m. MSMA House of Delegates, Crown Room
9:30 a.m. Auxiliary Finance Committee Meeting, Gallery D
12:00 noon Committee on Publications Luncheon, Gallery B
1:00 p.m. Annual Membership Meeting, Mississippi Foundation for Medical Care, Inc., Crown Room
2:00 p.m. Reference Committee on Reports of Officers, Board of Trustees and Councils, Crown Room
2:30 p.m. Auxiliary Preconvention Board Meeting, Gallery A
3:30 p.m. Council on Constitution and By-Laws Meeting, Gallery C
4:00 p.m. Gastrointestinal Seminar, Gallery B
4:00 p.m. Ole Miss Alumni Business Meeting, Ramada 4
5:30 p.m. Tulane University Medical Alumni Reception, Gallery D
6:00 p.m. University of Tennessee Medical Alumni Reception, Gallery C
7:00 p.m. University of Mississippi Medical Alumni Banquet, Ramada 1-4

TUESDAY, MAY 2, 1978

7:00 a.m. American College of Surgeons, Mississippi Chapter, Officers Breakfast, Ramada 1
7:00 a.m. Mississippi Dermatological Society Breakfast, Gallery A
7:30 a.m. MSMA Officers and Component Society Officers Breakfast, Ramada 2
9:00 a.m. American College of Surgeons, Mississippi Chapter, Scientific Meeting, Crown Room
9:00 a.m. MSMA Scientific Meeting—Section on Medicine, Ramada 3
9:00 a.m. MSMA Scientific Meeting—Section on Dermatology, Ramada 4
9:00 a.m. Auxiliary General Session, Gallery C and D
12:00 noon American College of Surgeons, Mississippi Chapter, Luncheon, Ramada 1
12:00 noon Mississippi Society of Internal Medicine Luncheon, Ramada 2
12:30 p.m. Mississippi Dermatological Society Luncheon, Gallery A
1:00 p.m. MSMA Scientific Meeting—Section on Radiology, Gallery B
1:00 p.m. Auxiliary Luncheon, Ramada 3 and 4
1:30 p.m. MSMA Scientific Meeting—Section on Pediatrics, Gallery C and D
1:30 p.m. MSMA Scientific Meeting—Section on Surgery, Crown Room
3:30 p.m. Auxiliary Postconvention Board Meeting, Gallery E

WEDNESDAY, MAY 3, 1978

7:30 a.m. Academy of Facial Plastic and Reconstructive Surgery Breakfast Meeting, Gallery B
7:30 a.m. MSMA Past Presidents' Breakfast, Ramada 2
8:00 a.m. Organizational Breakfast, State Perinatal Committee, Gallery A
9:00 a.m. MSMA Scientific Meeting—Section on Family Practice, Crown Room
9:00 a.m. Auxiliary Past Presidents' Breakfast, Ramada 1
9:00 a.m. MSMA Scientific Meeting—Section on EENT, Gallery C and D
11:00 a.m. MSMA Nominating Committee Meeting, Gallery E
12:00 noon MSMA 50 Year Club Luncheon, Gallery B
12:00 noon Mississippi Urological Society Luncheon, Gallery A

12:00 noon Mississippi Academy of Family Physicians Luncheon, Ramada 3 and 4
12:00 noon Mississippi EENT Association Luncheon, Ramada 2
12:00 noon Mississippi Ob-Gyn Society Luncheon, Ramada 1
1:30 p.m. MSMA Scientific Meeting—Section on Ob-Gyn, Crown Room
1:30 p.m. MSMA Scientific Meeting—Section on Preventive Medicine, Gallery C and D
6:00 p.m. MSMA Fellowship Party, Poolside

THURSDAY, MAY 4, 1978

9:00 a.m. MSMA House of Delegates, Crown Room

EXECUTIVE BUSINESS



DR. TAYLOR

C. D. Taylor, Jr.
Pass Christian
Speaker



DR. TRIPLETT

R. Faser Triplett
Jackson
Vice Speaker



DR. BUDD

HOUSE OF DELEGATES
May 1, 1978, 9:30 a.m.
Crown Room, Coliseum
Ramada Inn

MEETINGS OF THE HOUSE OF DELEGATES

The opening meeting of the House will be called to order by the President, and the speakers will announce the order of business. An open meeting on May 1, to which all MSMA members and Auxiliary members are invited will feature addresses by Dr. James O. Gilmore, the president, and Dr. John H. Budd of Cleveland, OH, president of the American Medical Association. The adjourned meeting of the House will convene at 9:00 a.m. on May 4.

REFERENCE COMMITTEES

Reports of Officers, Board of Trustees, and Councils, May 1, 2:00 p.m., or immediately following MFMC Meeting, Crown Room
Constitution and By-Laws, May 1, 3:30 p.m., Gallery C
Nominating Committee, May 3, 11:00 a.m., Gallery E

THE SCIENTIFIC ASSEMBLY

COUNCIL ON SCIENTIFIC ASSEMBLY

J. ELMER NIX, Chairman



DR. NIX

THE COUNCIL

KATHERINE ALDRIDGE, Chairman, Anesthesiology
DAVID I. CARLSON, Secretary
RONALD R. LUBRITZ, Chairman, Dermatology
THOMAS C. GARROTT, Secretary
DAVID E. ULMER, Chairman, EENT
W. JOSEPH BURNETT, Secretary
W. K. STEWART, Chairman, Family Practice
GENE E. CRICK, Secretary
WALTER T. BOONE, Chairman, Medicine
DON Q. MITCHELL, Secretary
RICHARD S. HOLLIS, Chairman, Ob-Gyn
WADIE ABRAHAM, Secretary
J. ELMER NIX, Chairman, Orthopaedic Surgery
GEORGE W. WHARTON, Secretary
ROLAND F. SAMSON, Chairman, Pathology
WILLIAM B. WILSON, Secretary
WILLIAM F. SISTRUNK, Chairman, Pediatrics
ROBERT H. THOMPSON, JR., Secretary
CLAUDE EARL FOX, Chairman, Preventive Medicine
W. E. RIECKEN, JR., Secretary
J. ED RUFF, Chairman, Psychiatry
GLEN ANDERSON, Secretary
JAMES T. TRAPP, Chairman, Radiology
BERNARD BLUMENTHAL, Secretary
BENTON M. HILBUN, Chairman, Surgery
JERRY R. ADKINS, Secretary

SCIENTIFIC AND TECHNICAL EXHIBITS

Royal and Regency Rooms, Coliseum Ramada Inn

THE SCIENTIFIC EXHIBIT

Physicians, foundations, organizations and major medical institutions will present the Scientific Exhibit. Physician-members of the Mississippi State Medical Association are eligible for the Aesculapius Award given for excellence of presentation, quality of content, and originality. Others may not participate in this competition, but they are eligible for the association's Scientific Achievement Award, a sculptured bronze medallion, in recognition of the best presentation by a non-member. The Scientific Exhibit is located in the Royal and Regency Rooms and lobby of the Coliseum Ramada Inn.

EXHIBITS AND AUTHORS

Prevent Blindness
Mississippi Society for the Prevention of Blindness

Community Service
American Heart Association—Mississippi Affiliate

Cranial Computed Tomography
Elmer J. Harris, Clifton L. Hester, and Allen R. Yates, Mississippi Baptist Medical Center, Jackson, MS

Disability Evaluation Under Social Security
John Cook, Administrator, and Ed Adams, Professional Relations Officer, Disability Determination Services, Jackson, MS

Computer Assisted Electrocardiography
H. Davis Dear, Jr., McKamy Smith, and Morris E. Williams, Mississippi Baptist Medical Center, Jackson, MS

Problem Pregnancy Services in Jackson, MS
Family Health Services, Jackson, MS

Non-Invasive Vascular Studies
Seshadri Raju, Department of Surgery, University Medical Center, Jackson, MS

Pain Clinic and Its Relations to General Medicine
Joseph S. Hudson, Kit S. Mays, William C. North, William L. Webb, and James T. Robertson, University of Tennessee-Center for the Health Sciences, Memphis, TN

Triple Valve Replacement with the Porcine Xenograft
Jeff Hollingsworth, Henry Tyler, William Rosenblatt, James Hays, James Crosthwait, Quinton Dickerson, Thomas Paine, Arthur Jones, and George McMullan, Mississippi Heart Institute-St. Dominic Hospital, Jackson, MS

CT Scanning of the Abdomen
T. S. McCay, J. W. Evans, E. L. Gieger, and P. E. Cranston, St. Dominic Hospital, Jackson, MS

THE TECHNICAL EXHIBIT

The Mississippi State Medical Association presents with pride the 1977 Technical Exhibit. Established firms engaged in the manufacture and distribution of pharmaceuticals, supplies, or equipment, and in providing varied services, will present the exhibits. Visit each exhibit often and discuss products and services with the Professional Service Representatives. Only registered members and guests are admitted. The technical exhibit is located in the Regency and Royal sections of the Empire Room at the Coliseum Ramada Inn.

EXHIBITORS

Ames Company, Elkhart, IN
Bedsole Surgical Supply, Mobile, AL
Blue Cross-Blue Shield of MS, Inc., Jackson, MS
Boehringer Ingelheim Ltd., Elmsford, NY
Bristol Laboratories, Syracuse, NY
CIBA Pharmaceutical Co., Summit, NJ
Comatic Laboratories, Inc., Houston, TX
Commerce General Corporation, Jackson, MS
Deposit Guaranty National Bank, Jackson, MS
Dista Products Company, Indianapolis, IN
Durr-Fillauer Medical, Inc., Mobile, AL
Flint Laboratories, Deerfield, IL
General Medical Jackson, Jackson, MS
Healthco/Mississippi Surgical, Jackson, MS
Hill Crest Hospital, Birmingham, AL
Hoechst-Roussel Pharmaceuticals, Inc., Somerville, NJ
Hospital Corporation of America, Nashville, TN
Kremers-Urban Company, Milwaukee, WI
Lanier Business Products, Jackson, MS
Mallinckrodt, Inc., St. Louis, MO
Martin Surgical Supply/Positive Air, Houston, TX
Medical Business Services, Inc., Jackson, MS
Merck Sharpe & Dohme, West Point, PA
Meyer Laboratories, Inc., Ft. Lauderdale, FL
Nutrilabs, Inc., Atlanta, GA
Paine Webber Jackson & Curtis, Inc., Jackson, MS
Pennwalt Prescription Products, Rochester, NY
Pfizer Laboratories, Doraville, GA
Phon-a-gram, Houston, TX
Wm. P. Poythress & Co., Inc., Richmond, VA
Reed and Carnrick, Kenilworth, NJ
A. H. Robins Company, Richmond, VA
Roche Laboratories, Nutley, NJ

Sandoz Pharmaceuticals, E. Hanover, NJ
South Central Bell, Jackson, MS
St. Paul Fire and Marine Insurance Co., St. Paul, MN
Stuart Pharmaceuticals, Wilmington, DE
Systemedics/AMS, Laurel, MS
The Travelers Insurance Company, Jackson, MS
Tutag Pharmaceuticals, Bloomfield, CO
U. S. Air Force, New Orleans, LA
U. S. Army Medical Department, Washington, DC
USV Laboratories, Tuckahoe, NY
Weapons Corporation of America, Hurst, TX
Weight Watchers of Greater MS, Jackson, MS
Wyeth Laboratories, Philadelphia, PA

Visit the Exhibits!

The technical exhibits provide financial support for the annual session. Visit the exhibit hall and extend your thanks to the professional service representatives.

REGISTRATION FOR EXHIBIT PRIZES

Visit the Technical Exhibits often and qualify for the drawing of attractive prizes. Obtain necessary initials as you visit each booth. Drawing for exhibit attendance prizes will be held at MSMA registration on Wednesday at 5:00 p.m.

SCIENTIFIC GRANTS

Eli Lilly and Company, Indianapolis, IN
Bristol Laboratories, Syracuse, NY
A. H. Robins Company, Richmond, VA

Special Sponsorship—President's Reception—The Mississippi Bank

Program is acceptable for 15 hours by the American Academy of Family Physicians and 15 hours Category I credit toward AMA Physician's Recognition Awards.

SCIENTIFIC PROGRAM—
Section on Pathology

Sunday, April 30, 1978
Gallery C Room
Beginning at 9:00 a.m.

Roland F. Samson, Jackson
Chairman
William B. Wilson, Jackson
Secretary



DR. SAMSON

SHORT COURSE IN:

MORPHOLOGIC DEFINITION AND BIOLOGICAL BEHAVIOR, EPITHELIAL HYPERPLASIAS AND IN SITU CARCINOMAS OF THE FEMALE BREAST

David L. Page, associate professor of pathology, Vanderbilt University, Nashville

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SCIENTIFIC PROGRAM—
Section on Orthopedic Surgery

Sunday, April 30, 1978
Ramada 2 Room
Beginning at 9:00 a.m.

J. Elmer Nix, Jackson
Chairman
George W. Wharton, Jackson
Secretary



DR. NIX

SHORT COURSES IN:

THORACAL LUMBAR SPINE FRACTURES

E. Shannon Stauffer, chairman of division of orthopaedics and rehabilitation, Southern Illinois University School of Medicine, Springfield

SPORTS INJURIES

Hugh Tullos, Baylor College of Medicine, Houston

SCIENTIFIC PROGRAM—
Section on Anesthesiology

Sunday, April 30, 1978
Ramada 4 Room
Beginning at 9:00 a.m.

Katherine Aldridge, Hattiesburg
Chairman
David I. Carlson, Jackson
Secretary



DR. ALDRIDGE

SHORT COURSE IN:

ANESTHESIA FOR THE PATIENT WITH ISCHEMIC HEART DISEASE

Roy D. Wilson, professor and chairman, Department of Anesthesiology, the University of Mississippi School of Medicine, Jackson

SCIENTIFIC PROGRAM—
Section on Psychiatry

Sunday, April 30, 1978
Ramada 3 Room
Beginning at 10:00 a.m.

J. Ed Ruff, Jackson
Chairman
Glen Anderson, Brandon
Secretary



DR. RUFF

SHORT COURSE IN:

PSYCHOMATIC DISORDERS
Melvin J. Steinhart, associate professor of psychiatry and medicine, Albany Medical College of Union University, Albany, NY

Supported by a grant from Pfizer.

SCIENTIFIC PROGRAM—
Section on Medicine

Tuesday, May 2, 1978
Ramada 3 Room
Beginning at 9:00 a.m.

Walter T. Boone, Jackson
Chairman
Don Q. Mitchell, Jackson
Secretary



DR. BOONE

SHORT COURSES IN:

MEDICAL VS. SURGICAL MANAGEMENT OF CORONARY ARTERY DISEASE—CONTINUED CONTROVERSY
Cecil Williams, Laurel

PATHOPHYSIOLOGICAL BASIS FOR TREATING DUODENAL ULCER DISEASE
Basil Hirschowitz, University of Alabama, Birmingham

A PRACTICAL APPROACH TO FLUID AND ELECTROLYTE EMERGENCIES—SOLVING AND PREVENTING THE PROBLEM
Gary Boone, Meridian

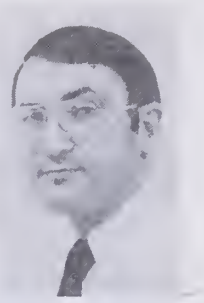
ENDOCRINE VISUAL IDENTIFICATION REVIEW
Roger L. Nelson, consultant in internal medicine and endocrinology, Mayo Clinic, Rochester, MN

Supported by grants from the Merck Sharp and Dohme Postgraduate Program, the Mead Johnson Postgraduate Program, and The Upjohn Company.

SCIENTIFIC PROGRAM—
Section on Dermatology

Tuesday, May 2, 1978
Ramada 4 Room
Beginning at 9:00 a.m.

Ronald R. Lubritz, Hattiesburg
Chairman
Thomas C. Garrott, Biloxi
Secretary



DR. LUBRITZ

SHORT COURSES IN:

PRESENTATION
W. Mage Honeycutt, clinical professor of dermatology, University of Arkansas, Little Rock

PANEL DISCUSSION ON DIAGNOSIS AND TREATMENT OF COMMON DERMATOLOGICAL PROBLEMS

SCIENTIFIC PROGRAM—
Section on Radiology

Tuesday, May 2, 1978
Gallery B Room
Beginning at 1:00 p.m.

James T. Trapp, Tupelo
Chairman
Bernard Blumenthal, Jackson
Secretary



DR. TRAPP

SHORT COURSE IN:

BODY IMAGING—C.T. SCANNING AND ULTRASOUND SCANNING
William F. Sample, Center for Health Sciences, UCLA Medical Center, Los Angeles

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SCIENTIFIC PROGRAM—
Section on Surgery

Tuesday, May 2, 1978
Crown Room
Beginning at 1:30 p.m.

Benton M. Hilbun, Tupelo
Chairman
Jerry R. Adkins, Biloxi
Secretary



DR. HILBUN

SHORT COURSES IN:

COLONIC CANCER
Arthur J. Donovan, professor and chairman, Department of Surgery, University of South Alabama, Mobile

DIAGNOSTIC AND THERAPEUTIC MEASURES FOR PERIPHERAL VASCULAR DISEASE
H. Edward Garrett, professor of surgery; chairman, thoracic and cardiovascular surgery, University of Tennessee College of Medicine, Memphis

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SCIENTIFIC PROGRAM
Section on Pediatrics

Tuesday, May 2, 1978
Gallery C and D
Beginning at 1:30 p.m.

William F. Sistrunk, Jackson
Chairman
Robert H. Thompson, Jackson
Secretary


DR. SISTRUNK

SHORT COURSES IN:

THE INFLUENCE OF TELEVISION VIOLENCE ON CHILDREN
Ronald S. Drabman, associate professor and director, Psychology Training Program, University of Mississippi School of Medicine, Jackson

THE COURSE AND PROGNOSIS OF ACUTE POSTSTREPTOCOCCAL GLOMERULONEPHRITIS IN CHILDREN
John E. Lewy, chairman, department of pediatrics, Tulane University School of Medicine, New Orleans

NEWBORN TRANSPORT PROBLEMS
Peter R. Honeyfield, co-director, Newborn Intensive Care Unit; director, Newborn Emergency Services; assistant professor of pediatrics, University of Colorado Medical Center, Denver

Supported by a grant from Ross Laboratories.

SCIENTIFIC PROGRAM—
Section on Family Practice

Wednesday, May 3, 1978
Crown Room
Beginning at 9:00 a.m.

W. K. Stewart, Pass Christian
Chairman
Gene E. Crick, Minter City
Secretary


DR. STEWART

SHORT COURSES IN:

EAR INFECTIONS
Michael H. Carter, Jr., Greenwood

FUNDAMENTALS OF DIABETES AND ITS TREATMENT
Charles R. Shuman, professor of medicine, Temple University School of Medicine, Philadelphia

CORONARY ARTERY DISEASE: RECENT CONCEPTS
H. Davis Dear, Jackson

USE OF PSYCHIATRIC DRUGS IN PSYCHIATRIC EMERGENCIES
P. Evans Adams, chairman, Department of Adult Psychiatry: Division of Psychiatry, Albert Einstein Medical Center, Northern Division, Philadelphia

Supported by grants from Lederle Laboratories and Pfizer.

SCIENTIFIC PROGRAM—
Section on EENT

Wednesday, May 3, 1978
Gallery C and D
Beginning at 9:00 a.m.

David E. Ulmer, Columbus
Chairman
W. Joseph Burnett, Oxford
Secretary


DR. ULMER

SHORT COURSES IN:

VITRECTOMY IN RETINAL DETACHMENT
Steven T. Charles, clinical assistant professor, Department of Ophthalmology, University of Tennessee Center for the Health Sciences, Memphis

NEW APPROACHES TO THE PITUITARY GLAND
Ronald E. Hubbard, clinical associate professor, Department of Otolaryngology and Maxillofacial Surgery, University of Tennessee Center for the Health Sciences, Memphis

PARS PLANA VITRECTOMY IN ANTERIOR SEGMENT PROBLEMS
Dr. Charles

EVALUATION OF THE DIZZY PATIENT
Dr. Hubbard

SCIENTIFIC PROGRAM—
Section on Preventive Medicine

Wednesday, May 3, 1978
Gallery C and D
Beginning at 1:30 p.m.

Claude Earl Fox, Tupelo
Chairman
W. E. Riecken, Jackson
Secretary



DR. FOX

SHORT COURSES IN:

REGIONALIZED PERINATAL CARE—Overall Topic
THE SOUTH CAROLINA APPROACH

Henry C. Heins, Jr., associate professor of Ob-Gyn, Medical University of South Carolina, Charleston; and consultant in maternal and child health, South Carolina State Health Department, Columbia

A COMMUNITY APPROACH IN MISSISSIPPI

Elin Holgren, maternity project coordinator, District III, Mississippi State Board of Health

THE ROLE OF THE PRIVATE MEDICAL SECTOR

Frank Wilburn, Tupelo

Panel Discussion

Supported by a grant from Ross Laboratories.

SCIENTIFIC PROGRAM—
Section on Ob-Gyn

Wednesday, May 3, 1978
Crown Room
Beginning at 1:30 p.m.

Richard S. Hollis, Amory
Chairman
Wadie Abraham, Meridian
Secretary



DR. HOLLIS

SHORT COURSES IN:

THE USE OF SERUM PROLACTIN IN GYNECOLOGY AND IN INFERTILITY

Richard P. Dickey, chief, section of reproductive endocrinology, Department of Obstetrics and Gynecology, Louisiana State University School of Medicine, New Orleans

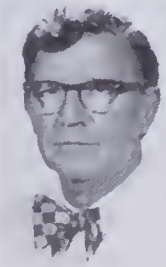
HIGH RISK OBSTETRICS

Hiram W. K. Batson, professor and acting chairman, Department of Obstetrics and Gynecology, Tulane University Medical School, New Orleans

OUT OF STATE ESSAYISTS



MELVIN J. STEINHART
Albany, NY



HENRY C. HEINS, JR.
Charleston, SC



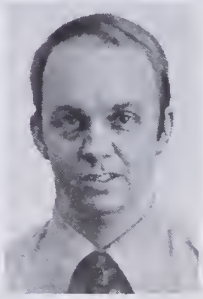
WILLIAM F. SAMPLE
Los Angeles



W. MAGE HONEYCUTT
Little Rock



HIRAM W. K. BATSON
New Orleans



STEVEN T. CHARLES
Memphis



BASIL HIRSCHOWITZ
Birmingham



ARTHUR J. DONOVAN
Mobile



RONALD E. HUBBARD
Memphis



ROGER L. NELSON
Rochester, MN



H. EDWARD GARRETT
Memphis



CHARLES R. SHUMAN
Philadelphia

ESSAYISTS / Continued



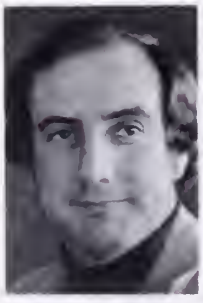
JOHN E. LEWY
New Orleans



P. EVANS ADAMS
Philadelphia



ROY D. WILSON
Jackson



PETER R. HONEYFIELD
Denver



DAVID L. PAGE
Nashville



E. SHANNON STAUFFER
Springfield, IL

SUNDAY, APRIL 30, 1978

MISSISSIPPI ASSOCIATION OF PATHOLOGISTS

On Saturday evening, April 29, the Mississippi Association of Pathologists is hosting a cocktail party for members, spouses and their guests at the Coliseum Ramada Inn. The cocktail party is being sponsored by Scientific Products, Division of American Hospital Supply Corporation. The pathologists will convene for their annual business meeting in conjunction with their scientific section meeting at 9:00 a.m., on Sunday, April 30, in Gallery C of the Coliseum Ramada Inn. The association will also host a luncheon in Gallery B Room at 12:30 p.m. on Sunday. Officers are Roland Samson of Jackson, president; William B. Wilson of Jackson, secretary; Allen M. Read of Natchez, president-elect; and David R. Steckler of Natchez, treasurer.

MISSISSIPPI ORTHOPEDIC SOCIETY

The Mississippi Orthopedic Society will host a luncheon meeting on Sunday, April 30, at 12:00 noon in Gallery A. Society officers are J. Elmer Nix of Jackson, president; Royce H. Franks of Tupelo, president-elect; George W. Wharton of Jackson, secretary; and Hugh P. Brown of Jackson, vice president.

MISSISSIPPI PSYCHIATRIC ASSOCIATION

The Mississippi Psychiatric Association will hold a luncheon at 12:00 noon on Sunday, April 30, in Ramada I. President is J. E. Ruff of Jackson; president-elect is G. Howard Freeman of Meridian; and secretary is A. G. Anderson of Brandon.

MISSISSIPPI SOCIETY OF ANESTHESIOLOGISTS

The Mississippi Society of Anesthesiologists will host a dinner meeting with a guest speaker on Sunday evening, April 30, at 6.00 p.m. in Gallery B. On Monday, May 1, the society will sponsor a brunch at 9:00 a.m. in Ramada I. Officers are Katherine Aldridge of Hattiesburg, president; Dexter C. Nettles of Jackson, president-elect; and David I. Carlson of Jackson, secretary-treasurer.

PRESIDENT'S RECEPTION

The annual President's Reception honoring the president of the AMA and other officers will be held in the Crown Room of the Coliseum Ramada Inn on Sunday, April 30, from 6-7:30 p.m. MSMA members and their spouses are invited to attend. The Mississippi Bank is sponsoring the reception this year.

MONDAY, MAY 1, 1978

GASTROINTESTINAL SEMINAR

The Mississippi Gastroenterology Society will sponsor a Gastrointestinal Seminar to be conducted on Monday, May 1, at 4:00 p.m. in Gallery B of the Coliseum Ramada Inn. Officers of the society are president, Walter T. Boone of Jackson; secretary, Joel T. Callahan of Meridian; and executive committee, Leonard Posey of Jackson and James E. Spence of Hattiesburg.

Program: Diseases of the Colon—Dr. Walter T. Boone, Moderator. Irritable Colon—Dr. George Smith-Vaniz; Inflammatory Bowel Disease—Dr. James Q. Sones; Diverticular Disease—Dr. Joel Callahan; Cancer—Dr. William McKell; and Colonoscopy—Dr. Tom Crowson plus a panel discussion. Admission fee is $5.00. The meeting is open to all.

REFERENCE COMMITTEE BREAKFAST

Members of all reference committees of the House of Delegates will meet for breakfast on Monday morning, May 1, in Gallery B at 8:00 a.m. Hosts are C. D. Taylor, Jr., of Pass Christian, speaker, and R. Faser Triplett of Jackson, vice speaker. At this important meeting, committee members will be instructed in their duties and conduct of hearings to be held later in the day.

MISSISSIPPI FOUNDATION FOR MEDICAL CARE

The Mississippi Foundation for Medical Care will hold its annual meeting on Monday afternoon, May 1, beginning at 1:00 p.m. in the Crown Room. All members are urged to attend.

TULANE MEDICAL ALUMNI

Medical graduates of Tulane University will be feted at a reception on Monday evening, May 1, in Gallery D at 6:30 p.m. Ms. Margie Fell, TMAA coordinator, is making the arrangements.

UNIVERSITY OF TENNESSEE MEDICAL ALUMNI

Medical alumni of the University of Tennessee and guests will enjoy a reception on Monday evening, May 1, in Gallery C from 6:00 to 8:00 p.m. John Sheridan, UT director of alumni affairs, is in charge of arrangements.

OLE MISS MEDICAL ALUMNI

University of Mississippi medical alumni, families and guests will meet on Monday, May 1, at the Coliseum Ramada Inn. Alumni registration will be located adjacent to MSMA general registration in the lobby and will be open at 8:00 a.m. where tickets for the evening party at 7:00 p.m. will be available. A general business meeting will be held at 4:00 p.m. on Monday in Ramada 4. Kenneth Reed of Jackson is program planning chairman. Other committee members are Barry B. Aden, Hobson D. Brock, James E. Keeton, and Richard L. Yelverton, all of Jackson. R. Faser Triplett of Jackson is medical alumni president and L. Stacy Davidson of Cleveland is president-elect.

The Medical Alumni Guardian Society will also meet during the MSMA annual session. The annual business meeting will be held on Sunday, April 30, in Gallery A at 3:30 p.m. That evening the society will host a cocktail party and dinner for members and their special guests at 7:00 p.m. in Ramada 2-4. Dr. Davidson is chairman of the Guardian Society and Kelly S. Segars of Iuka is vice chairman. Members of the planning committee are Fred L. McMillan, of Jackson, chairman, and Walter T. Boone and Lawrence W. Mahalak, both of Jackson.

TUESDAY, MAY 2, 1978

MISSISSIPPI SOCIETY OF INTERNAL MEDICINE

The Mississippi Society of Internal Medicine will have a luncheon on Tuesday, May 2, at 12:00 noon in Ramada 2. James C. Hays of Jackson is president and Bruce E. Atkinson of Amory is secretary-treasurer.

AMERICAN COLLEGE OF SURGEONS, MISSISSIPPI CHAPTER

The American College of Surgeons, Mississippi chapter, will sponsor a scientific program on Tuesday morning, May 2, beginning at 9:00 a.m. in the Crown Room. The program is:

Pancreatic and Peri-Pancreatic Cancer
Arthur J. Donovan, Mobile

Care of the Acutely Ill or Post Surgical Patient
H. Edward Garrett, Memphis

Fellows will adjourn for luncheon in Ramada 1 at 12:00 noon. Officers of the college are John R. Lovelace of Batesville, president; James D. Hardy of Jackson, president-elect; and W. Briggs Hopson of Vicksburg, secretary. ACS officers will meet for breakfast on Tuesday at 7:00 a.m. in Ramada 1.

MISSISSIPPI DERMATOLOGICAL SOCIETY

The Mississippi Dermatological Society will host breakfast and luncheon meetings on Tuesday, May 2. The breakfast will be at 7:00 a.m. in Gallery A and the luncheon will follow the Section on Dermatology meeting and will be in Gallery A at 12:30. Officers of the society are Ronald R. Lubritz of Hattiesburg, president, and Tom Garrott of Biloxi, secretary-treasurer.

MSMA OFFICERS BREAKFAST

On Tuesday, May 2, at 7:30 a.m. in Ramada 2, the MSMA Board of Trustees, officers and component society presidents and secretaries will hold a breakfast meeting to discuss MSMA organization and activities.

WEDNESDAY, MAY 3, 1978

ACADEMY OF FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY

The Academy of Facial Plastic and Reconstructive Surgery will host a breakfast on Wednesday, May 3, at 7:30 a.m. in Gallery B. Officers of the academy are Kenneth Reed of Jackson, president; George Arrington, Jr., of Meridian, vice president; and J. George Smith of Jackson, secretary.

ASSOCIATION FELLOWSHIP PARTY

Members of the Mississippi State Medical Association, their families and guests will enjoy a fellowship cocktail party on Wednesday evening, May 3, around the pool, beginning at 6:00

p.m. Tickets are available at the MSMA registration desk.

MSMA PAST PRESIDENTS' BREAKFAST

Past presidents of the Mississippi State Medical Association will enjoy a fraternal breakfast on Wednesday morning, May 3, at 7:30 a.m. in the Ramada 2. Dr. Lyne S. Gamble of Greenville is host.

FIFTY YEAR CLUB

The Board of Trustees, sponsors of the assoeiation's Fifty Year Club, will honor the half-century plus members at a speeial luncheon on Wednesday, May 3, at 12:00 noon in Gallery B. Robert S. Caldwell of Tupelo, ehairman of the Board of Trustees, will preside.

MISSISSIPPI OB-GYN SOCIETY

The Mississippi Ob-Gyn Society will host a luncheon and business meeting on Wednesday, May 3, in the Ramada 1 beginning at 11:30 a.m. Offieers of the society are Kenneth Pittman of Jackson, president; H. Lamar Gillespie of Hattiesburg, president-elect; Lewis Lipscomb of Jaekson, viee president; and Fred Ingram of Jaekson, seeretary-treasurer.

MSMA TENNIS TOURNAMENT

MSMA will sponsor a tennis tournament with men's and women's doubles on Wednesday afternoon, May 3. Dr. Henry B. Tyler of Jaekson is chairman.

MISSISSIPPI EENT ASSOCIATION

The Mississippi EENT Assoeiation will hold a luneheon and business session on Wednesday, May 3, at 12:00 noon in Ramada 2. Assoeiation offieers are Leighton Pettis of Tupelo, president; James Gordon of Jackson, viee president; and Wilson Moak of Jackson, seeretary-treasurer.

MISSISSIPPI ACADEMY OF FAMILY PHYSICIANS

The Mississippi Academy of Family Physicians will sponsor a luncheon meeting at 12:00 noon on Wednesday, May 3 in Ramada 3 and 4. Guest speaker will be P. Evans Adams, ehairman, department of adult psyehiatry, Albert Einstein Medieal Center, Philadelphia. Dr. Evans will diseuss "The Basement Druggist—No Lieense, Labcl or Ethies." Offieers of the academy are Ralph L. Brock of McComb, president; John M. Estess of Hollandale, president-eleet; and J. Edward Hill of Hollandale, secretary.

MISSISSIPPI UROLOGICAL SOCIETY

The Mississippi Urological Society will sponsor a luncheon meeting at 12:00 noon on Wednesday, May 3, in Gallery A. William Gates of Columbus is president; Toxey Morris of Hattiesburg is president-eleet; and Ronald L. Brown of Gulfport is seeretary-treasurer.

MISSISSIPPI STATE MEDICAL ASSOCIATION AUXILIARY

55th Annual Session — Coliseum Ramada Inn
April 30-May 3, 1978



MRS. HILBUN



MRS. ROWLETT

OFFICERS

MRS. WILLIAM M. HILBUN, JR. Tupelo President	MRS. SAM ROWLETT Vicksburg President-Elect
MRS. J. C. BARNETT, JR. Brookhaven 1st Viee President	MRS. W. P. WARFIELD Moss Point 2nd Viee President
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MRS. JAMES B. MARTIN Oeean Springs Recording Secretary	MRS. WILLIAM A. BILLUPS Meridian Corresponding Secretary
MRS. DOYLE P. SMITH Jackson Treasurer	MRS. W. A. BROWN, JR. Mathiston Parliamentarian

AUXILIARY

Sunday, April 30, 1978

2:00-6:00 p.m. Registration and Welcome Booth, Ramada Lobby

Monday, May 1, 1978

9:00 a.m.-5:00 p.m. Registration, Ramada Lobby
9:30 a.m. Finance Committee Meeting, Gallery D
2:30 p.m. Preconvention Board Meeting, Gallery A
3:30 p.m. Coffee and Tour
Mississippi Arts Center
201 East Pascagoula Street
All members are invited

Tuesday, May 2, 1978

9:00-12:00 noon Registration, Lobby
9:00 a.m. Coffee, Gallery C and D
9:15 a.m. General Session, Gallery C and D
Invocation
Welcome
Response
Introductions
Greetings
Mrs. Chester L. Young, President, AMA Auxiliary
James O. Gilmore, M.D., President, MSMA
Carl G. Evers, M.D., President-Elect, MSMA
Norman C. Nelson, M.D., Dean, Mississippi Medical School
Memorial
Roll Call
Minutes
Appointment of Delegates to AMA Auxiliary Annual Meeting
Business
Election of Officers
Installation of Officers
Courtesy Resolutions
Adjournment
1:00 p.m. Luncheon, Ramada Rooms 3 and 4
Invocation
Introductions
Guest Speakers
John H. Budd, M.D., President, AMA
Mrs. Chester L. Young, President, AMA Auxiliary
Awards
Presentation of Officers
Entertainment
3:30 p.m. Postconvention Board Meeting, Gallery E

Wednesday, May 3, 1978

9:00 a.m. Past Presidents' Breakfast, Ramada Room 1
10:00 a.m.-2:00 p.m. AMA-ERF Benefit

AUXILIARY ANNUAL SESSION
COMMITTEE CHAIRMEN

Convention Chairman
Mrs. George Arrington, Meridian

★ ★ ★

Registration
Mrs. Stewart Williford, Hattiesburg
Hattiesburg Medical Auxiliary

★ ★ ★

Sunday Welcome Booth
Mrs. J. C. Barnett, Jr., Brookhaven
South Central Medical Auxiliary

★ ★ ★

Monday Afternoon Coffee
Mrs. Richard S. Hollis, Amory — Mrs. Ben Buchanan, Tupelo
Northeast Mississippi Medical Auxiliary

★ ★ ★

Tuesday Luncheon
Mrs. Joel Callahan, Meridian — Mrs. William B. Simmons, Meridian
East Mississippi Medical Auxiliary

★ ★ ★

Wednesday House and Garden Tour
Mrs. Robert J. Hargis, Clinton — Mrs. Henry H. Webb, Jackson
Central Medical Auxiliary

★ ★ ★

Hospitality
Mrs. T. A. Baines, Jackson — Mrs. John C. Suares, Greenville
Washington County Medical Auxiliary

★ ★ ★

Hostesses
Mrs. J. Edward Hill, Hollandale — Mrs. W. A. Brown, Jr., Mathiston

★ ★ ★

Publicity
Mrs. Curtis Roberts, Brandon



The President Speaking

"Are We Giving It Away?"

JAMES O. GILMORE, M.D.
Oxford, Mississippi

For many years physicians have lightened their work load by parceling out to non-medical assistants such tasks as laboratory tests, intramuscular injections, and follow-up blood pressure readings. Some of the assistants had been trained as nurses and others as technicians. Many had no formal training, but learned in the manner of apprentices from the physicians for whom they worked. Radiologists and other physicians using diagnostic x-ray equipment trained their own personnel. Surgeons and later anesthesiologists trained nurses to administer anesthesia. Orthopedic surgeons trained cast technicians. Psychiatrists have employed psychologists to help them in management of patients.

Training in physical therapy, occupational therapy and recreational therapy has developed rapidly into professional programs with advanced degrees. We now have such specialities as respiratory therapist, "ostomy" nurses, and exercise physiologist. In addition we have specialists in speech and hearing. Specific programs now exist for all these specialities and under the title of "School of Allied Health Services."

Shortly after World War II, the physicians assistants program began. Several programs were started with the idea of training medical corpsmen, however it soon became apparent that other people were interested. In spite of licensing difficulties and a small demand, some of these programs still exist.

The nursing profession has developed a nurse practitioner program. Pharmacy schools are now training students to take a more active role in supervising drug therapy, absorbing some of the prerogatives of both nurses and physicians.

We no longer have a shortage of physicians in the United States, due mainly to an influx of foreign graduates and the fact that over 110 four-year medical schools are turning out more graduates than ever before. There are problems in some rural areas but these will not be solved by increasing the number of available physicians. If we continue to expand the role of "paramedical" personnel, what will be the role of the physicians in total health care? I think it is time that we give some serious thought to the questions and take some specific action.

MSMA's 110th annual session will be held at the Coliseum Ramada Inn, May 1-4, 1978. I would encourage all of you to attend.

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XIX, NUMBER 4
APRIL 1978

Microsurgery—An Expanding Field

The operating microscope was developed and introduced by a German optical company in the 1930's. This instrument, with its built-in coaxial light source, allowed free use of both hands in a well illuminated field viewed with binocular vision. Otolaryngologists immediately recognized the usefulness of the microscope in visualizing structures deep in the ear. In fact, further development of this instrument and recognition of its versatility and usefulness by otolaryngologists is responsible for the rapid growth and expansion of the entire field of otolaryngology in the 1950's. Modern otologic microsurgery began in that era as a direct result of the availability of this instrument. Otolaryngologists have for many years used the microscope in numerous other ways. Microsurgery of the larynx is now a recognized subdivision within the specialty. Facial nerve repair, salivary duct surgery, intricate sinus surgery, and numerous other procedures have been performed regularly under the operating microscope. In addition, the field of office otology has been greatly enhanced by the use of this instrument in the clinical area.

Recently, other clinical services have come to realize the advantages of this instrument. Ophthalmic microsurgery is a rapidly expanding field. Other recently developing fields of microsurgery are centered around peripheral nerve repair, hand surgery, microvascular surgery, microreconstructive surgery centering around the microvascular free tissue transfer of intestine, bone, and composite skin grafts, intracranial neurological surgery and transnasal hypophysectomy. With more widespread usage of this instrument, further advancements will occur. National meetings dedicated entirely to microsurgery have appeared on the scene and in some institutions Fellowships in microsurgery are available. Recognition of the usefulness of the operating microscope, and its adoption by other clinical specialists, will lead to improved patient care, in many instances decreased hospital stay, decreased morbidity, and the development of procedures not previously available.

MYRON W. LOCKEY, M.D.
Associate Editor

Cost Commission Report: Answer Before Too Late

The AMA-created National Commission on the Cost of Medical Care—in submitting its report with 48 recommendations—has given America a bold and far-ranging statement of *what* has to be done about that cost. And among physicians, there are bound to be *why's*.

* *Why was the commission created?*

Because the AMA recognized the damage and danger inherent in the relentless surge in health-care costs—an average of 11 per cent a year. And because the AMA, as the nation's largest physician organization, was the logical choice to take the lead in curbing that surge and in reducing costs where possible.

* *Why was the commission composed of representatives from a variety of fields—including industry, insurance, labor, government, and academia —instead of being limited to physicians and health-care institutions?*

Because on an issue affecting as many fields and as many people as health-care costs, a panel lacking breadth of membership would also lack credibility. Conclusions reached by persons of like opinion generally excite little attention outside their own group, in contrast with the widely favorable notice the commission report has received in the media and elsewhere. Even so, 11 of the 27 commission members are physicians, and one is a dentist.

* *Why are some of the 48 recommendations at variance with medicine's established way of doing things and even with AMA policy?*

Because *every* group involved directly or indirectly with health care must put cost containment ahead of certain other considerations.

NEW MEMBERS

BARKSDALE, BRYAN, Jackson. Born Jackson, MS, May 6, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned Duke University, Durham, NC, 1972-73; internal medicine residency, UMC, Jackson, 1973-76; elected by Central Medical Society.

CARGILE, KENNETH R., New Albany, MS. Born Laurel, MS, Dec. 14, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned and family practice residency, Medical Center, Columbus, GA, 1974-77; elected by Northeast Mississippi Medical Society.

FLORES, THOMAS R., Corinth. Born Phillippines, April 26, 1935; M.D., Far Eastern University, Manila, Philippines, 1963; interned Norton Medical Infirmary, Louisville, KY, one year; surgery residency, same, 1966-67; surgery residency, Charity Hospital, New Orleans, LA, 1967-68; surgery residency, Touro Infirmary, New Orleans, 1968-69; surgery residency, Charity Hospital, New Orleans, 1969-70; elected by Northeast Mississippi Medical Society.

HUTCHINS, WILEY C., Columbus. Born Charleston, MS, Sept. 19, 1931; M.D., University of Mississippi School of Medicine, Jackson, 1960; interned City of Memphis Hospitals, Memphis, TN, one year; orthopedic surgery residency, Kennedy V.A. Hospital, Memphis, 1961-62; orthopedic surgery residency, Campbell Foundation, Memphis, 1962-65; elected by Prairie Medical Society.

JONES, KEN C., Jackson. Born Jackson, MS, Nov. 21, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned and ophthalmology residency, same, 1973-76; elected by Central Medical Society.

LIPSCOMB, LARRY R., Jackson. Born Jackson, MS, Mar. 10, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1965; interned and ob-gyn residency, UMC, Jackson, MS, 1965-69; elected by Central Medical Society.

MCAULEY, MALCOLM D., Tupelo. Born Memphis, TN, Oct. 18, 1938; M.D., University of Mississippi School of Medicine, Jackson, 1963; interned Baptist Memorial Hospital, Memphis, TN, 1963-64; Otolaryngology residency, University of Alabama, Birmingham, 1966-70; elected by Northeast Mississippi Medical Society.

REED, JOHN E., JR., Columbus. Born West Point, MS, Dec. 22, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned and internal medicine residency, University of Alabama, Birmingham, AL, 1973-76; elected by Prairie Medical Society.

RHODEN, RICHARD E., Jackson. Born Columbia, MS, Mar. 21, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned and psychiatry residency, UMC, Jackson, MS, 1972-75; elected by Central Medical Society.

SONES, JAMES Q., II, Jackson. Born Meridian, MS, April 19, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned and internal medicine residency, UMC, Jackson, MS, 1972-75; gastroenterology residency, University of Texas, Dallas, TX, 1975-77; elected by Central Medical Society.

WOOLDRIDGE, THOMAS D., Tupelo. Born Grenada, MS, Feb. 25, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned University Hospital, Jacksonville, FL, 1972-73; internal medicine residency, UMC, Jackson, MS, 1973-75; nephrology, same, 1975-77; elected by Northeast Mississippi Medical Society.

DEATHS

DI SANTI, NICHOLAS, Pascagoula. Born New York City, NY, April 25, 1925; M.D., Tulane University, New Orleans, LA, 1959; interned and ob-gyn residency, Charity Hospital, New Orleans, 1959-63; died Jan. 25, 1978, age 52.

STRANGE, W. W., Booneville. Born Cotton Plant, MS, July 28, 1891; M.D., University of Tennessee College of Medicine, Memphis, 1924; interned St. Joseph Hospital, PA, 1924-25; died Feb. 4, 1978, age 87.

MCVEY, ERIC A., JR., Jackson. Born Lambert, MS, Dec. 16, 1916; M.D., Baylor College of Medicine, Houston, TX, 1950; interned Baptist Memorial Hospital, Memphis, TN, 1950-51; died Feb. 5, 1978, age 61.

PERSONALS

RICHARD C. BORONOW of Jackson attended the annual meeting of the Society of Gynecologic Oncologists in Key Biscayne and was installed as 10th president of the society.

LEWIS COOK of Marks was elected president of the medical staff of the Quitman County Hospital. M. B. LYNCH was named vice president and C. S. PHELPS, secretary-treasurer.

W. MEL FLOWERS, JR., of Jackson and UMC attended a council meeting of the southeastern chapter, Society of Nuclear Medicine, in Birmingham.

THOMAS GANDY of Natchez was guest speaker at the Natchez Community Hospital public awareness program entitled, "Do You Think You Are Having a Heart Attack?"

WILLIAM GARY of Tupelo has been elected chairman of the medical staff for 1978 at North Mississippi Medical Center.

P. W. HILL, JR., announces the opening of his office for the practice of general medicine and surgery at 601 East Second Street, Executive Plaza, in Clarksdale.

A. C. JACKSON of Jackson was elected to the American Board of Urology in February.

SAMUEL B. JOHNSON of Jackson and UMC spoke to a staff conference of the Florida Rehabilitation Center for the Blind in Daytona.

A. J. MESSINA of Vicksburg was honored with a special presentation and certificate by members of the Mississippi Association of Public Health Physicians on the occasion of his retirement as Warren County health officer.

PAUL L. ODOM has opened his office in the Medical Arts Building on Highway 7 South of Water Valley for the practice of family medicine.

CHARLES RAY of Meridian is new president of the Mississippi Radiological Society. Other officers are JAMES T. TRAPP of Tupelo, president-elect; KENNETH G. CARTER of Jackson, first vice president; REBECCA S. HARRELL of Jackson, second vice president; and JOHN Y. GIBSON of Jackson, secretary.

PAUL A. ROBERTSON announces the opening of his office as a family practitioner in the Coastal Medical Center, Gateway Executive Park, in Biloxi. Dr. Robertson, a graduate of Tulane University, has joined the medical staff at Gulf Coast Community Hospital.

FREDERICK GEORGE SEXTON has opened his offices at 303 S. Dauphine Street in Poplarville for the practice of family medicine in association with RON RENNICK.

ROBERT SMITH of Jackson and UMC presented a paper at the American Heart Association meeting in New Orleans during February.

JOSEPH G. SPRINGER has been elected chief of staff at Gulf Coast Community Hospital for the 1978-79 term. Other new officers are: CLAY EASTERLY, chief of staff-elect; CLYDE O. HAGOOD, secretary-treasurer; DONALD RAYNER, chief of medicine; and FRANK LANSDEN, chief of surgery.

JAMES TATE THIGPEN of Jackson and UMC was named one of three Outstanding Young Men of Mississippi during the Mississippi Jaycees annual winter board convention in Natchez.

RHEA L. WYATT retired recently as health officer in Public Health District I after serving the Mississippi State Board of Health for more than 36 years.

POSTGRADUATE CALENDAR

April 13-14, 1978
NEWBORN RESUSCITATION
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics Division of Newborn Medicine and the University Medical Center Division of Continuing Health Professional Education.

Coordinator: Gwendolyn Bussa, M.N., assistant professor of nursing, University of Mississippi School of Nursing, and instructor in obstetrics and gynecology, University of Mississippi School of Medicine.

This two-day course will emphasize the manual skill of resuscitation with lectures on the principles of resuscitation. Management of the mechanical and pharmacologic needs of the resuscitated newborn will be stressed. The course is limited to six participants. Fee: $50.00. Credit: 15 contact hours, 1.5 CEU, Category 1, AMA; AAFP applied for.

POSTGRADUATE / Continued

May 5-6, 1978
FOCUS ON DIABETES

Holiday Inn Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Medicine, the University Medical Center Division of Continuing Health Professional Education and the Juvenile Diabetes Foundation of Mississippi.

Coordinator: Karleen C. Neill, M.D., assistant professor of medicine, University of Mississippi School of Medicine.

Pediatric and adolescent insulin-dependent diabetics will be discussed during this one and one-half day workshop. The first day is for physicians only; the second day of the workshop will include a roundtable discussion open to the public. Fee: $25.00 for physicians, $5.00 for laymen. Credit: 9 contact hours, .9 CEU, Category 1, AMA; AAFP applied for.

May 11-12, 1978
NEWBORN NUTRITION
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics Division of Newborn Medicine and the University Medical Center Division of Continuing Health Professional Education.

Coordinator: Gwendolyn Bussa, M.N., assistant professor of nursing, University of Mississippi School of Nursing, and instructor in obstetrics and gynecology, University of Mississippi School of Medicine.

Open to physicians, nurses and other health professionals, this two-day seminar will focus on the newborn's nutritional needs. There will be a fee. Credit: Category 1, AMA; AAFP applied for.

May 19-20, 1978
ADVANCED CARDIAC LIFE SUPPORT
PROVIDERS COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Anesthesiology and the University Medical Center Division of Continuing Health Professional Education.

Coordinator: William W. Bradford, M.D., emergency room physician, Singing River Hospital, Pascagoula; and Thomas J. Herrin, M.D., associate professor of anesthesiology, University of Mississippi School of Medicine.

This two-day course is limited to 48 physicians who have been certified by the American Heart Association in basic life support. Participants must have a thorough knowledge of external heart massage and assisted ventilation. Fee: $125.00. Credit: 12 contact hours, 1.2 CEU, Category 1, AMA; AAFP; American College of Emergency Physicians.

FUTURE CALENDAR

May 25-26, 1978
AGING
University Medical Center, Jackson

May 25-26, 1978
NEWBORN RESUSCITATION
University Medical Center, Jackson

June 12-13, 1978
NEWBORN CARE FOR PHYSICIAN AND NURSE TEAMS
University Medical Center, Jackson

Mississippi Medical Assistants Attend Symposium

Over 100 medical assistants from over the state attended the Seventh Annual Educational Symposium held at Primos Northgate in Jackson on Feb. 18.

Dr. Faser Triplett, an allergist with the Mississippi Allergy Clinic, spoke on "Stinging Insects." "How to Live for the Rest of Your Life—A New Health Concept" was presented by Dr. James Spell, breast surgeon, Jackson; Dr. Raymond Grenfell, internal medicine, Jackson, spoke on "Hypertension." Dr. Thomas Allen, Senior Fellow, Division Digestive Diseases, U.M.C., spoke on "Good News, It's Only Hepatitis!" Charles Mathews, Executive Secretary of the Mississippi State Medical Association, gave the highlights of the legislative session which pertained to the medical field. Thomas E. Freeland, Ph.D., School of Health Related Professions at the University of Mississippi, rounded out the program speaking on "Medical Education—Yours."

One of the objectives of American Association of Medical Assistants is to provide educational services which will increase the knowledge and professionalism of its members and to stimulate a feeling of fellowship and cooperation among its societies.

Lift the Quality of Medicine You Practice to A New High!



American Medical Association/127th Annual Convention
June 17-21, 1978/St. Louis

Continuing Medical Education Highlights!
The whole purpose of the AMA's CME program is to help you do what attracted you to medicine in the first place: provide the high quality care your patients need.

The scientific program is geared to help you do exactly that. Emphasis is on the *practical* aspects of new developments—clinical information of immediate use in your practice. Whether you're in primary care or a specialty, the large selection of courses allows you to focus on those areas in which you want to update your knowledge. The program features:

- 55 Category 1 Postgraduate Courses
- 30 Sessions, 20 Telecourses, 13 Clinical Dialogues, 3 Motion Picture Seminars — all Category 1 and FREE OF CHARGE
- 100 Scientific and 125 Industrial Exhibits
- 3 AMA Auxiliary Sessions (no credit)

The New Spirit of St. Louis!
New convention center. New hotels. New attractions. There's a whole new look and spirit in St. Louis today. With lots of things to do and see. Soar to the top of the nation's tallest monument, the Gateway Arch. . .beat your feet to rollicking ragtimers aboard a showboat. . .dine on gourmet French cuisine whose recipes came up the river from New Orleans. . .visit the hospitality room of the world's largest brewer. The new Spirit of St. Louis is yours to enjoy at the 127th AMA Annual Convention.

PLAN NOW TO ATTEND
For complete information, return this coupon today.

Dept. of Meeting Services
American Medical Association
535 N. Dearborn/Chicago, IL 60610

Please send me complete information on the 127th AMA Annual Convention in St. Louis as soon as it becomes available.

Name_____

Address_____

City/State/Zip _____

MSMA Tennis Tournament

Register Now!



Wednesday Afternoon,
May 3, 1978
Jackson, MS

Men's and Women's
Doubles

Chairman: Dr. Henry B. Tyler, Jackson (Telephone 948-1411)

Mail form below to Dr. Tyler, c/o MSMA, P.O. Box 5229, Jackson 39216

I would like to register for the MSMA Tennis Tournament:

Name

Address

More details will be published in the MSMA Blue Sheet and will be available at MSMA Registration, Coliseum Ramada Inn.

MEDICAL ORGANIZATION

MSMA Board of Trustees Meets in Jackson

MSMA's Board of Trustees conducted its regular winter meeting in Jackson March 16.

This was the last meeting of the Board prior to the association's 110th Annual Session in Jackson, April 30-May 4, and primary business coming before the board consisted of annual reports to the House of Delegates.

Reports from the Board to the House of Delegates will recommend provisional association endorsement of Blue Cross-Blue Shield of Mississippi, Inc., adoption of an MSMA-Mississippi Bar Association Interprofessional Code, and commissioning of a public opinion poll on health care in Mississippi.

The Board will also bring to the attention of the delegates reports on the ongoing operations of the association, health legislation, and the State Board of Health lawsuit.

In other actions the Board requested a recommendation from Central Medical Society concerning whether to continue alternating MSMA annual sessions between Jackson and the Gulf Coast, and went on record in support of a recommendation from the MSMA Council on Medical Education to the House of Delegates that the association required continuing medical education as a condition for membership in the association beginning in 1980-83.

The Board also reviewed plans for the association to sponsor a voluntary cost containment program with the Mississippi Hospital Association and heard plans of MSMA's Council on Medical Service to establish a disabled physicians program.

In other action dealing with a Council on Medical Service recommendation, the Board will recommend to the House of Delegates that the association through its individual members immediately begin to formulate health goals for the state reflecting the medical profession's views in this regard.

C. B. Mitchell Lecture Is This Month

The annual C. B. Mitchell Lecture at Mississippi State University will be April 4, 1978. Guest speaker for this year's lecture is Dr. Donald C. Kent, Medical Director of the Life Extension Institute and associate professor of clinical medicine, New York University, New York City. Dr. Kent is board certified in internal medicine and pulmonary diseases.

The C. B. Mitchell Lecture series was instituted at MSU to improve the quality of pre-medical education there. Dr. C. B. Mitchell was the father of two Mississippi physicians, Dr. C. B. Mitchell, Jr., of Meridian and Dr. Tom Mitchell of Vicksburg.

For more information, contact Dr. John C. Longest, Student Health Center, P.O. Box 5448, State College, MS 39762.

UMC Adds New Faculty Members

An assistant professor and an instructor have been named to the faculties at the University of Mississippi Medical Center.

UMC Vice Chancellor Dr. Norman C. Nelson announced the appointments following approval of the Board of Trustees, Institutions of Higher Learning.

Joining the UMC centerwide faculty is Dr. Richard Charles Hunt, assistant professor of biochemistry. Dr. Sudha Velamati is School of Medicine instructor in neurosurgery (research).

Dr. Hunt comes to the Medical Center from England, where he has been departmental demonstrator in biochemistry at the University of Oxford since 1976. He will assume his UMC duties July 1. Dr. Hunt is a B.A., M.A. and Ph.D. graduate of Cambridge University in England He held postdoctoral fellowships at the University of Virginia Medical School from 1972-1975 and at the University of Toronto from 1975-1976.

Dr. Sudha Velamati, who joined the faculty in February, has been a physician's assistant at the Tom Bailey Clinic in Maben since 1976. He earned the P.V.C. degree at the Government Arts College in Sirkakulam, India, in 1964 and the M.B.B.S. degree at Andhra Medical College in Visakhapatnam, India, in 1973. Dr. Velamati took residency training at the Government Headquarters Hospital in Elurie, India, from 1973-1976 and held a postdoctoral fellowship in neurosurgery at the Mississippi Medical Center in 1977.

Family Medicine Fund Receives Gift



Dr. Ralph L. Brock of McComb, left, president of the Mississippi Academy of Family Physicians, presented a $1,000 check to the academy's development fund during the group's Feb. 25-26 meeting at the University of Mississippi Medical Center. Dr. Brock is also clinical instructor of family medicine at the UMC. Dr. Wilfred Gillis, UMC professor of family medicine and chairman of the department, accepted the check on behalf of the academy. The gift is from the L. W. and Dannie T. Brock Fund, established in 1969 by the McComb Infirmary Association, Inc., in memory of Dr. Brock's parents. The money will be used to assist family medicine training in the state.

Lung Disease Symposium Set for Georgia

The third annual Symposium on Lung Disease will be held June 14-18, 1978, at the Cloister, Sea Island, GA. This is a symposium on the diagnosis and management of lung disease for practicing physicians.

For more information, contact Betty Rafshoon, Georgia Lung Association, 1383 Spring Street, N.W., Atlanta, GA 30309, (404) 876-3601.

Dr. Longest Directs Smoking and Health Program



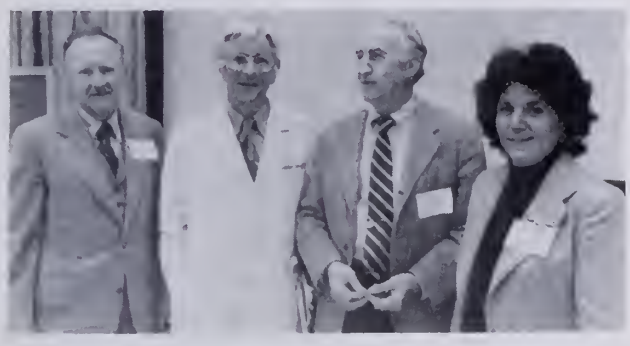
Dr. John C. Longest (left) of Mississippi State University, newly elected chairman of the Board of Directors, National Interagency Council on Smoking and Health, will direct activities of the council during the coming year. Dr. Longest represents the American College Health Association, one of 34 member organizations in the national council. Dr. Longest, director of Student Health Services, Mississippi State University and physician to the M.S.U. basketball and football teams, is pictured with H.E.W. Secretary Joseph A. Califano, Jr., and Mrs. Robert W. Huff of Rome, GA, past-chairman of NICSH. Dr. Longest is also a member of the Mississippi Interagency Council on Smoking and Health.

UMC Hosts Valentine Party for Former Patients



Four-year-old E. J. Gregory was among young Mississippians who attended a special Valentine's Day party at the University of Mississippi Medical Center. E. J. is the son of Mr. and Mrs. Jack Gregory of Morton, left. Gregory, a member of the New York Giants football team, and his family make their home in Mississippi during the off-season. Most of the youngsters who came to the party were high risk newborns who required special care to survive. Dr. John E. Rawson, right, UMC associate professor of pediatrics and newborn center director, was on hand to help welcome the now-healthy children.

Medical Center Sponsors Hypertension Seminar



More than 50 Mississippi physicians participated in a course on hypertension at the University of Mississippi Medical Center in February. Dr. Herbert G. Langford, second from left, UMC professor of medicine, coordinated the seminar which was sponsored by the UMC School of Medicine Department of Medicine and the Medical Center Division of Continuing Health Professional Education. Partial funding was from Pfizer, Inc. Guest faculty included, from left, Dr. James Woods, professor of medicine, University of North Carolina School of Medicine; Dr. Carlos Ayres, professor of medicine, University of Virginia School of Medicine; and Dr. Maria New, professor of pediatrics and co-chairman of the department, Cornell School of Medicine.

Jackson Hosts Fungus Disease Symposium

A Fungus Disease Symposium is set for April 14-15 at the Coliseum Ramada Inn in Jackson. Sponsors are the Mississippi Baptist Medical Center Continuing Education Committee and the Mississippi Lung Association and Thoracic Society.

The aim of the conference is to provide practicing physicians useful information regarding the diagnosis and treatment of the human mycoses which are increasingly prevalent in this geographic region.

Attendance is by invitation and advanced registration is required. The course has been approved for 12½ hours of credit by the AMA Physicians Recognition Award and the American Academy of Family Physicians.

Local and guest faculty will present the program. For more information, contact Dr. John F. Busey, director, Continuing Medical Education, Mississippi Baptist Medical Center, Jackson, MS 39201 (601/968-5130).

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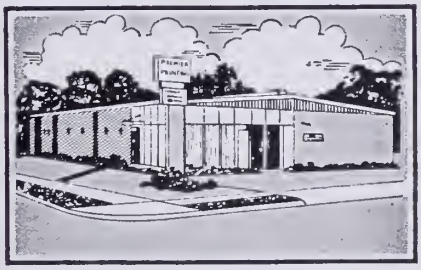
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MEETINGS

National and Regional

American Medical Association, Annual Convention, St. Louis, June 17-22, 1978. House of Delegates interim session, Chicago, Dec. 2-6, 1978. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

Emergency Medical-Surgical Care, Ochsner Medical Institutions, April 17-22, 1978. P. B. Johnson, Program Director, 1516 Jefferson Hwy., New Orleans, LA 70121.

Cardiopathy of Aging IV (Heart disease in the elderly patient), Little Rock, AR, May 16-17, 1978, by the Veterans Administration, University of Arkansas College of Medicine, Council on Clinical Cardiology and Tri-State Scientific Sessions of the American Heart Association. Program Director J. E. Doherty, M.D., 300 E. Roosevelt Rd., Little Rock, AR 72206.

State and Local

Mississippi Academy of Family Physicians, Annual Meeting, July 12-15, 1978, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 110th Annual Session, May 1-4, 1978, Jackson. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Henry McCrory, Secy., P.O. Box 340, Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. G. L. Arrington, Jr., Secy., P.O. Box 4128 West Station, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1167, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Bernard Hunt, Secy., 1196 Mound St., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. James M. Cooper, Secy., 605 Garfield St., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. George Walker, Secy., 102 W. Lampkin St., Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. D. W. Lamppin, Secy., P.O. Drawer J, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Clyde Allen, Secy., 1245 N. 6th Ave., Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

Mississippi Institutions and Organizations Accredited for Continuing Medical Education

The following Mississippi institutions and medical organizations have been accredited in accordance with the "Essentials for Accreditation of Institutions and Organizations Offering Continuing Medical Education Programs" of the Liaison Committee on Continuing Medical Education. Information concerning CME programs for physicians offered by these accredited sources may be obtained by writing the individual institution or organization.

Mississippi State Medical Association
Council on Scientific Assembly
Box 5229
Jackson, MS 39216
Charles L. Mathews, Executive Director

Mississippi Urological Association
118 Broad Avenue
Gulfport, MS 39501
Ronald L. Brown, M.D., Secretary

Mississippi Radiological Society
University Medical Center
2500 North State Street
Jackson, MS 39216
John Y. Gibson, M.D., Secretary

Mississippi Chapter, American College of Surgeons
The Street Clinic
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Mercy Regional Medical Center
Vicksburg, MS 39180
John R. Shell, M.D., Chairman, Medical Education Committee

Mississippi Baptist Medical Center
1225 North State Street
Jackson, MS 39201
John F. Busey, M.D., Director of Medical Education

Delta Medical Center
1400 E. Union Street
Greenville, MS 38701
W. C. Yarbrough, M.D., Chairman, Medical Education Committee

Northwest Mississippi Regional Medical Center
Box 1218
Clarksdale, MS 38614
Glenn Wegener, M.D., Chairman, Medical Education Committee

General Psychiatric Problems Seminar Slated

"Psychiatric problems in general practice" will be the topic of a postgraduate seminar to be held at Riverside Hospital in Jackson on April 29.

The program will consist of introduction of psychiatric problems encountered by the physician in general or family practice and present an overview of symptoms that should be recognized as beginning psychiatric disorders.

The morning session will feature a panel discussion on depression. Dr. Thomasina Blissard will give an overview of the symptoms and treatment of various forms of depression and discuss the mildest to most severe forms of depression as well as present some theories of causes. Dr. J. E. Ruff will discuss current drug therapy in the treatment of depression with therapeutic dose regimes, route of administration, and adverse reactions. Dr. Willard Waldron will talk about the therapeutic value of ECT in the treatment of depression, the dramatic results obtained from ECT and indication in the depressed patient for ECT.

In the afternoon, Dr. Billy T. Collum will discuss common problems in child psychiatry, incidence of parent/child conflicts, peer relationships, adolescent identity crisis, difficulties of children in dealing with emotions and feelings.

An alcoholism and drug abuse panel will consist of Dr. George D. Ladner, Dr. F. S. Covington, and Dr. William J. Gillespie, Jr. discussing theories about the causes of alcoholism, physical and psychological dependency of drugs and alcohol, the dependent personality of individuals to escape from reality, and dangers of creating prescription drug addicts.

There will be a registration fee of $50.

For further information contact Mrs. Jamie Hughes, CME Director, Riverside Hospital, Box 4297, Jackson 39216 (939-9030).

UMC Alumni Host Visiting Lecturer

Dr. George V. Mann, professor of biochemistry and medicine at Vanderbilt University, was at the University of Mississippi Medical Center as the medical alumni chapter's "distinguished lecturer" in January. Dr. Mann whose main research interest is coronary heart disease, lectured medical students on nutrition. Dr. Mann is the author of over 200 scientific publications and a book, "Food and Health," is in press.

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Index to Advertisers

Air Force ... 8
AMI/Eastern Region ... 19

Burroughs Wellcome Co. ... 10B

Canton Exchange Bank ... 16

Dermik Laboratories ... second cover
Doctors Needed ... 16

Harreld Chevrolet-Oldsmobile ... 87
Hill Crest Hospital ... 14

Eli Lilly and Co. ... 18
Loma Linda Food Co. ... 12

Mead Johnson Laboratories ... 74A, 74B, 74C, 74D

Parke, Davis and Co. ... 15
Pharmaceutical Manufacturers Assoc. ... 10D, 11
Premier Printing Co. ... 87

Riverside Hospital ... 6
Roche Laboratories ... 3, 10, 10A, third and fourth covers

Smith Kline and French ... 10C

The Upjohn Company ... 17

Warren-Teed Pharm., Inc. ... 7

Thomas Yates and Co. ... 4

IN CONCLUSION

MSMA's Board of Trustees has announced plans to commission an independent public opinion poll to determine how Mississippians feel about their health care. The poll will serve as a basis for planning future Mississippi State Medical Association programs as well as provide data for possible public information campaigns to correct erroneous views about health care. Present plans call for poll to be conducted this summer. Hospitals and physicians' offices will be asked to assist with getting poll to the public.

The International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM) will be published in May 1978, according to the publisher, the Commission on Professional and Hospital Activities. ICD-9-CM is the new disease classification system to be used for hospital coding of medical records, ambulatory and other medical care programs; furnishing clinical descriptions of patients; conducting clinical and epidemiological research; psychiatric coding; and reporting, compiling, and comparing health care data.

Association Films announces the release of "Doctors for People," a 27 minute color film about the role of, and need for, family doctors in modern society. Sponsored by the American Academy of Family Physicians, this documentary film is available on a free loan basis from Association Films, 866 Third Avenue, New York, NY 10022. "Doctors for People" shows that the family physician approaches his or her patients in terms of their total lives and treats the whole family. The film stresses personalized care.

An apparently well organized segment of trial lawyers led efforts to defeat the tort reform recommendations of the Interporfessional Commission on Medical Professional Liability at the recent American Bar Association meeting in New Orleans. Rejected were such recommendations as limits on compensation for pain and suffering and contingent fees. Parenthetically, it should be noted that at the same meeting Chief Justice Burger noted incompetency among courtroom lawyers and suggested that legal profession should emulate medical profession with respect to training.

Recent MSMA co-sponsored workshop for medical assistants drew an enthusiastic response from participants and requests from those who couldn't get in because of limits on registration for workshops. Additional workshops are now being planned for later this year in North, Central and Southern areas of the state. The workshops which are presented by AMA Practice Management Department personnel, are limited to 50 participants to encourage audience participation. Watch for further information in the MSMA "Blue Sheet" and Journal MSMA.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

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Journal of the State Medical Association

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For additional information contact: John R. Reedy, Executive Director.



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CONTENTS

ORIGINAL PAPER

Blood Viscosity Determinations Directly From the Vein — **89** VAN B. PHILPOT, M.D., RUNE STJERNHOLM, Ph.D., H. J. BLAKENEY, M.D., BRUCE ATKINSON, M.D., W. T. OAKES, M.D., B. O. MOORE, M.D., PAUL WHITESIDE, M.D., CHARLES SECREST, M.D., and LEWIS BLACK, M.T., Houston, MS

SPECIAL ARTICLES

Case Report XVIII of Maternal Mortality Study — **93** W. W. WALLEY, M.D., Waynesboro, MS

Radiologic Seminar CLXXXI: Whole Body Computed Tomography in the Abdomen — **96** SCOTT MCCAY, M.D., Jackson, MS

EDITORIALS

The Problem of Inflation — **99** W. MONCURE DABNEY, M.D., Crystal Springs, MS

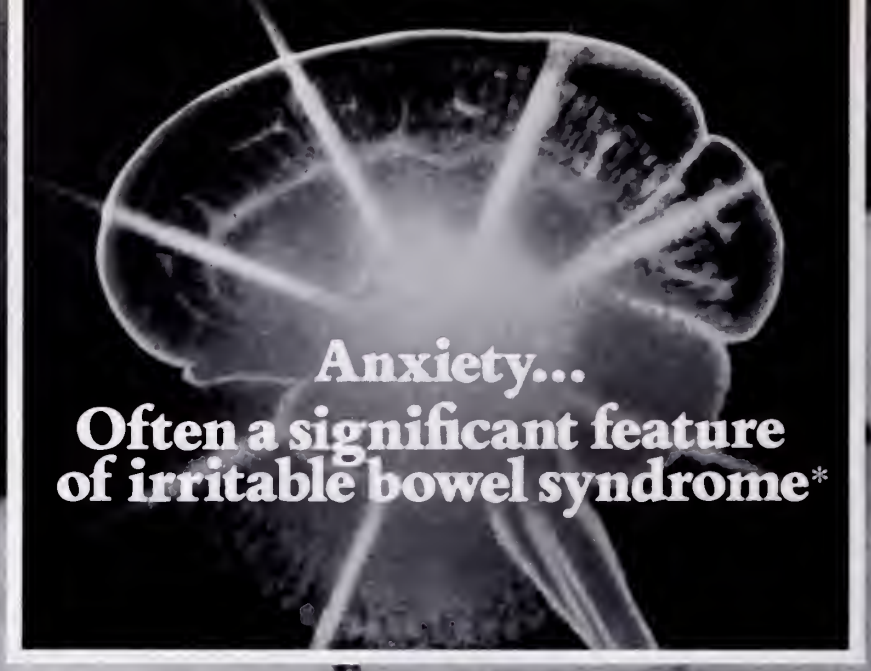
May Is High Blood Pressure Month — **99** NOLA GIBSON, Jackson, MS

THIS MONTH

The President Speaking — **98** More Controls

Medical Organization — **103** Senate Voids Finch's SBH Appointees

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Librax is unique among G.I. medications in providing the specific antianxiety action of Librium® (chlordiazepoxide HCl) as well as the potent antisecretory and antispasmodic actions of Quarzan® (clidinium Br) for adjunctive therapy of irritable bowel syndrome* and duodenal ulcer.

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on following page.

ROCHE

Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701

Medicare Forms Are Explained

An important reason why many people with protection under Medicare medical insurance have problems collecting money due them is that they fail to properly complete Form 1490—"Request for Medicare Payment," according to John F. Pate, social security district manager in Jackson.

It is very important that all blanks on the form be properly completed and that full information is given, said Pate. Incorrect or incomplete information can delay payment.

If the doctor or supplier accepts assignment, he or she completes the form and sends it in. If not, it is up to the patient to do so. Part I of the form must be completed in every case. Part II must also be completed or itemized bills attached.

Itemized bills must contain the proper information before any Medicare payment can be made, Pate emphasized. If the bill received does not have all of the following information, the patient should ask the doctor or supplier for it:

- A complete description of each service or supply received.
- The date each service or supply was received.
- The place each service or supply was received.
- The charge for each service or supply.
- The name of the doctor or supplier who provided each service or supply.
- The patient's name and full health insurance number, just as shown on the Medicare card. (The patient can add this information if not already on the bill.)
- It is helpful, although not necessary, if the diagnosis is shown on the bill.

More than one itemized bill can be sent with a single request for payment. It does not matter whether all the bills are from one doctor or supplier, or from different doctors or suppliers. And, the bills do not have to be paid first.

It is a good idea to keep a record of each claim. "Your Medicare Recordkeeper," a folder with space for bills and records, can be obtained at the Jackson social security office.

The request for payment and itemized bills should be sent to the proper Medicare carrier. If not shown on the request for payment form, the correct address can be found in "Your Medicare Handbook."

A leaflet, "How to Complete the Request for Medicare Payment" is also available at the Jackson social security office. The address is 666 North Street, Jackson 39202 and the telephone number is 948-5841.

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NEWSLETTER

May 1978

Dear Doctor:

The Secretary of HEW reports regularly to the Congress and the public on progress in reducing the rate of errors in Supplemental Security Income (SSI), the cash assistance program for the needy, aged, blind and disabled. During February the secretary reported "encouraging" findings from the latest six-month sampling, April-September 1977. There were during that measuring period $3.1 billion in SSI payments, and the payment error rate dropped to 5.2%--well below the prior 6.3%.

> According to Califano, the reduction saved the American taxpayer $30 million and the error rate was the lowest since the Social Security Administration began administering the program in January 1974. Computer checking of applicants' other income resulted in the reduction.

The American Medical Association testified 22 times in 1977 at hearings before Congress or federal agencies. In addition, the AMA submitted 90 statements to Congress, the White House, the National Governors' Conference, and federal agencies. Among the communications were 20 on drugs, seven on health manpower, and six on health planning.

Four national health insurance proposals were reviewed by the National Advisory Committee for NHI. One of the plans, or some combination of them, apparently will constitute the NHI proposal that will be sent to Congress later this year by the Administration. All plans called for substantial federal role, but the amount of control ranged from moderate to almost complete.

The 1978 Congressional races, particularly in Mississippi where a Senate and House seat are up for grabs, offer an excellent opportunity to question candidates about health issues sure to be before Congress next year. Some questions might be: Are you in favor of a national health insurance program? Are you in favor of a mandatory hospital cost containment program?

Recommended reading for all physicians is the recently published JCAH Monograph entitled "Medical Staff By-Laws." Written in brief narrative form, the monograph describes the framework and purpose of medical staff by-laws. "Medical Staff By-Laws"may be purchased from JCAH at $6 per copy. Orders should be addressed to: Publications Manager, JCAH, 875 N. Michigan Avenue, Chicago, IL 60611.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

California RVS's Are Recalled

The California Medical Association has recalled more than 27,000 copies of its relative value studies under terms of a consent agreement with the Federal Trade Commission. The FTC charged that the relative value index helped physicians fix prices in violation of anti-trust laws.

The president of CMA, Dr. E. K. Rose, said "We feel that the courts would eventually uphold the legality of the RVS, but fighting the issue in the courts probably would cost millions of dollars and take many years—easy for big government but an impossibility for CMA. Therefore, we have reluctantly decided to take the only course that is fiscally feasible and that is to stop issuing the RVS."

Several other medical organizations have withdrawn their relative value studies under similar conditions in the past two years. "It is ironic," Dr. Rose said, "that while FTC insists that the RVS no longer can be used by physicians, it is still used by government agencies to determine payment levels for their own health programs."

FDA Issues Blood Labeling Requirement

More than two years after first proposing them, the Food and Drug Administration has issued Donor Classifications Labeling Requirements for blood effective May 15, 1978.

The new requirements amend biologics regulations by requiring that each container of whole blood and blood components intended for transfusion bear the label statement "paid donor" or "volunteer donor" as applicable. The stated purpose of the regulation is to reduce the risk of hepatitis associated with transfusion therapy.

The regulation was issued over strong objections from the American Association of Blood Banks. The regulation essentially adopts the AABB's definition of paid and volunteer donors; namely, "a paid donor is a person who receives monetary payment for a blood donation." Benefits received for donating blood such as time off from work and membership in a blood assurance program do not constitute monetary payment.

Strong but unsuccessful efforts were made in 1976 Regular Session of the Mississippi Legislature to label blood.

BRIEF SUMMARY OF
PRESCRIBING INFORMATION

ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

More detailed professional information available on request.

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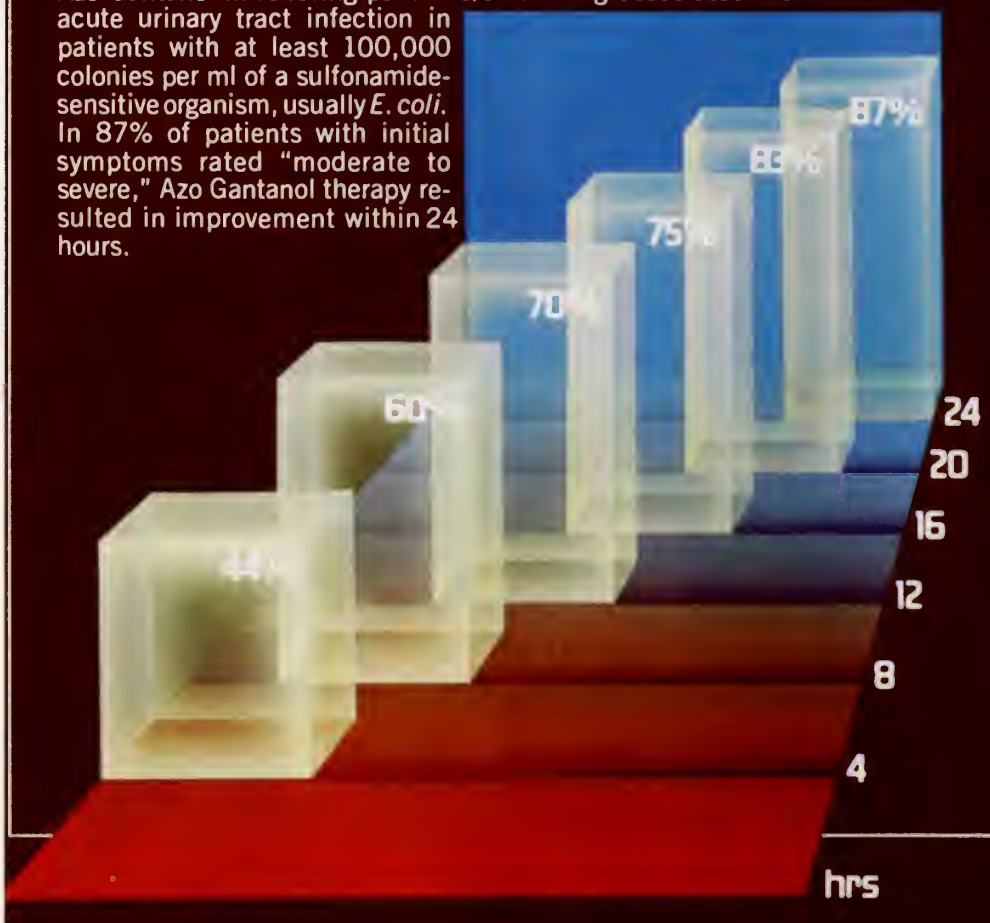
Please see brief summary of prescribing information on facing page

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Important data on the pain of acute cystitis:

In 87% of patients studied [303 of 349], Azo Gantanol® reduced pain and/or burning within 24 hours*

A controlled, multicenter study assessed the efficacy of Azo Gantanol in relieving pain and/or burning associated with acute urinary tract infection in patients with at least 100,000 colonies per ml of a sulfonamide-sensitive organism, usually *E. coli*. In 87% of patients with initial symptoms rated "moderate to severe," Azo Gantanol therapy resulted in improvement within 24 hours.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

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for the pain

for the pathogens

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110.

Physicians and Families Workshop Planned

This summer The Menninger Foundation is again sponsoring two workshops for "Physicians and Their Families" to be held in Estes Park, CO, June 18-23, 1978, and Aug. 13-18, 1978. Last year's workshop was well received and provided a stimulating experience for all involved. These workshops have been specially designed to reacquaint the physician with family dynamics and the stages families go through in their growth.

The American Academy of Family Physicians has given approval for 25 prescribed hours of continuing education credit. The workshop is also accredited for 25 hours of AMA continuing medical education credit in Category I of the Physician's Recognition Award.

For more information, contact Erwin T. Janssen, M.D., director, Division of Continuing Education, The Menninger Foundation, Box 829, Topeka, KS 66601.

PSRO Announces Changes In Funding

HEW's Health Care Financing Administration (HCFA) has issued a proposed regulation which changes the method of funding Professional Standards Review Organizations (PSROs) from procurement contract to grants. The proposed regulation also established organization and application requirement that must be met by an organization seeking to be designated as a PSRO.

"We believe that procurement contracts are not the appropriate way to support PSROs," said HCFA Administrator Robert A. Derzon. "We favored the amendment to the PSRO statute that permits PSRO financing to be accomplished by grants, and we believe the grant system should be started as soon as possible."

To be eligible for a grant, an organization must be qualified as a Priority PSRO or an Alternate PSRO. A Priority PSRO is a physician-composed association with a membership that includes at least 25 per cent of the physicians in a given area. An Alternate PSRO is an organization considered by HEW to be suitable and professionally competent—it may be a non-physician group which can show that it has or can obtain services of individuals with medical expertise to perform review activities competently.

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DATELINE

A health care costs program for medical students at the University of Oregon School of Medicine will be financed by a $100,000 grant from Oregon Physicians Service-Blue Shield. The grant is believed to be the first of its kind. Last year the AMA House of Delegates passed a resolution urging medical schools to institute cost-awareness programs. In a related action last spring the nation's med school deans urged the corporate community and the general public to provide the financial support needed to underwrite new teaching methods and curricular experiments.

Mississippi is one of 15 to 20 Professional Standard Review Organizations that have been chosen as "the best" PSROs to show "what the program is capable of doing." In the aftermath of the bruising fiscal year '79 budget recommendation of the Office of Management and Budget that the program be defunded, Health Care Financing Administration has selected the PSROs for studies aimed at showing the program is effective. Secretary of HEW Califano has come to the defense of the PSRO programs stating his support for their continued operation.

The woman who is pregnant or plans to become pregnant is the target of a new pamphlet being distributed by the National Institute on Alcohol Abuse and Alcoholism. The pamphlet, "Alcohol and Your Unborn Baby," states that drinking by the expectant mother could endanger the health of the fetus and suggests that, if she chooses to drink, she should limit her intake per day to no more than one ounce of absolute alcohol--the approximate equivalent of two mixed drinks, two glasses of wine or two 12-oz. cans of beer.

A 1978 Indiana statute provides that all hospitals which provide "general medical and surgical hospital services shall provide emergency hospital service in accordance with rules and regulations adopted by the board of health, to all alleged rape victims, male or female, who apply for such hospital emergency services in relation to injuries or trauma resulting from the rape." Services rendered by hospitals pursuant to the statute shall be provided without charge to the patient; hospitals will be reimbursed by the state board of health.

Too many stressful life events can drive a person to crime. A study of life events happening to men prior to incarceration in prisons found a mounting accumulation of life change events and an increase in life change magnitude that achieves crisis proportions in the year prior to incarceration in prison. The report in the Archives of General Psychiatry listed the life events as death of a spouse, loss of a job or breakup of a marriage, trouble with the boss, financial difficulties, arguments within the family or personal injury or illness.

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FTC Criticizes Blues-MD Relationships

The Federal Trade Commission has charged that the nation's Blue Shield plans are dominated by physicians—"an arrangement that may reduce competition and raise prices artificially."

FTC Chairman Michael Pertschuk told the Interstate and Foreign Commerce Committee's subcommittee on Oversight and Investigations that "—it is difficult to see how the public interest can be served by such an apparent conflict of interest."

He said that an ongoing FTC investigation has found that "most" of the 72 Blue Shield plans are controlled by local medical societies, other physicians' groups or "self-perpetuating physicians boards" set up to run the plans.

Meanwhile in Mississippi, Blue Cross-Blue Shield is seeking MSMA endorsement at this year's House of Delegates meeting and the plan's Board of Directors was recently expanded to a majority of public members. MSMA has not endorsed and named physician members to the Board of the state plan since 1968.

Kennedy Pushes New NHI Approach

Senator Edward M. Kennedy, organized labor's champion for its brand of national health insurance (NHI), is reported backing away from his original proposal for total federal domination of health care financing.

While President Carter plans to stick by his campaign promise to labor for an Administration-backed NHI proposal, it has become clear in all quarters that the Health Security Act—the organized labor and Kennedy sponsored plan—has no chance whatsoever of passage due to its price tag alone.

The significant strategy change is designed to boost chances for enactment of a NHI bill within the next few years and to hitch labor in tandem with the Carter Administration on the issue.

The Administration is expected soon to release a position paper staking out the type of NHI plan the President wants approved.

Labor made a strenuous effort earlier to get the Administration to support its Health Security Act, but the Administration balked, telling labor leaders such a plan was too expensive and could not win congressional endorsement.

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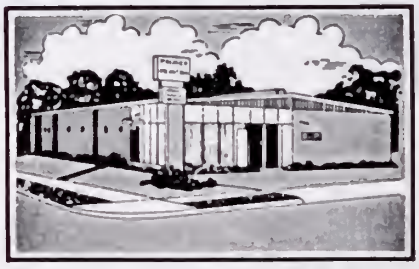
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Rural Clinics Will Be Paid

The federal government has begun certifying rural health clinics in Mississippi and other states that will be eligible for Medicare and Medicaid reimbursement for services provided by licensed nurse practitioners. Services of physicians' assistants are also covered in states where they are licensed.

The payments are being made under the Rural Health Services Act (Public Law 95-210) passed by Congress last year in a stated effort to increase health services in rural areas where there is a severe shortage of physicians.

The law states that to be eligible for government funds a clinic must have at least one nurse practitioner or physician assistant providing care under the supervision of at least one physician.

The reimbursement rate will be calculated by dividing total clinic expenses by total anticipated home and clinic visits. An annual adjustment will then be made based on actual expenses and visits.

AMA Hits MD Fee Report

The American Medical Association immediately branded a White House Wage-Price Stability Council report on soaring physician fees a "political hatchet job."

"The report is built on old data and faulty research," James H. Sammons, AMA Executive Vice President said.

The report said doctor bills are increasing half again as fast as the overall inflation rate and that the situation may get worse. It also accused the AMA of trying to limit the number of doctors in practice.

"We are incredulous that this unit of the executive branch of the government would publish a press release and summary report that is not substantiated in the body of the report itself," Dr. Sammons said.

He said the AMA has actively worked to increase the number of medical schools and practicing physicians in this country. Almost 16,000 doctors are now graduated from U. S. Medical Schools each year, about double the number of five to seven years ago, Dr. Sammons said, adding that the charge is "just plainly ridiculous."

He said the data about physicians' income and fees in the report are incorrect.

The study said that two years ago the median income of physicians was $63,000. The AMA, which yearly publishes statistical studies of medical practices, says the projected median for 1976 is $54,000

and that the actual median, before taxes, for 1975 was $50,337.

"That's not even close to the incredible figures being used in the report," Dr. Sammons said.

AMA Annual Meeting Is Set for St. Louis

The 127th Annual Convention of the American Medical Association will be held June 17-21 in St. Louis.

The 1978 gathering will mark the end of the giant AMA annual summer meeting. After more than a century of big conventions, the AMA is shifting emphasis toward multiple smaller sessions across the nation, aimed at providing continuing medical education for physicians.

Some 26 of the regional meetings are scheduled for 1979, offering physicians the opportunity to study on weekends, thus minimizing time away from their patients. Doctors will be able to select meetings closer to home, reducing travel time and expense. The regional meeting concept has been building within the AMA for a number of years, and will reach a new peak in 1979 as the big national meeting is phased out.

The AMA will continue to hold the annual winter scientific meeting each year. It will be in Las Vegas in 1978.

Program for the 127th Annual Convention is published in the April 21 issue of the *Journal of the American Medical Association.*

The June convention will offer physicians 55 continuing education courses covering the entire range of problems of diagnosis and treatment encountered by the doctors in their offices. Experts in each medical area will bring to the physicians the latest information on how to deal with disease.

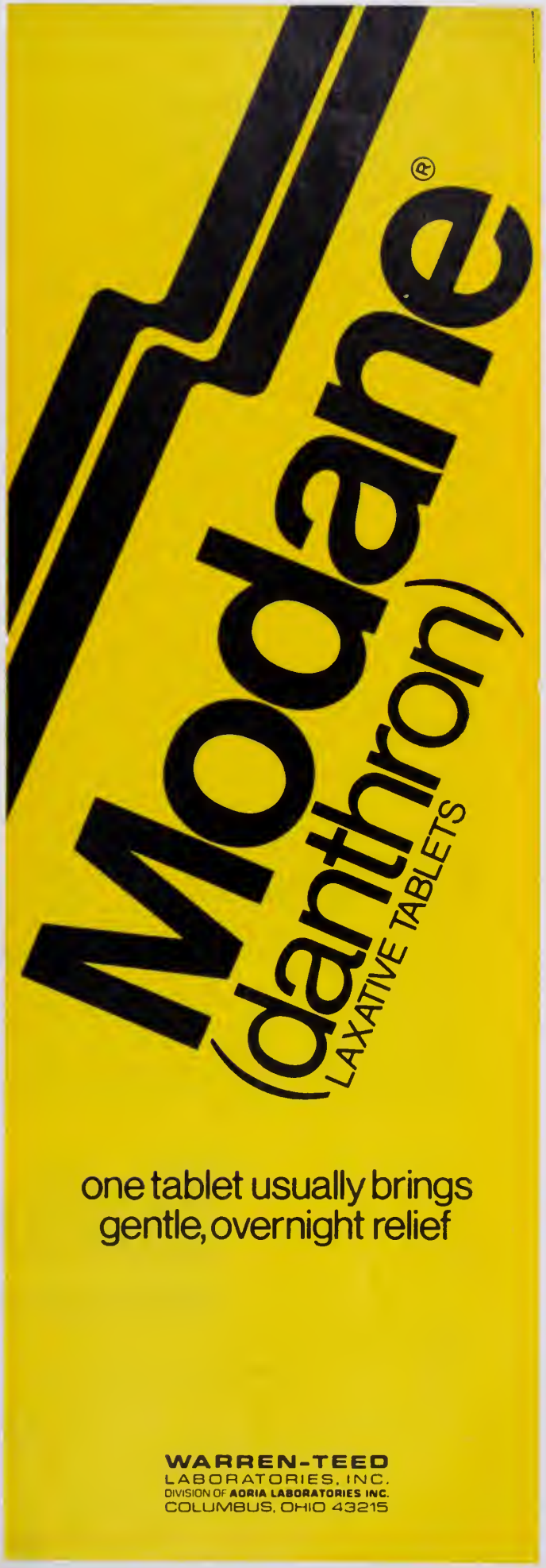
General sessions of the convention will deal with, "The Endorphin Story," "Coronary Bypass Surgery," "Effect of Moderate Drinking" and "Newer Development in Computed Tomography Scanning."

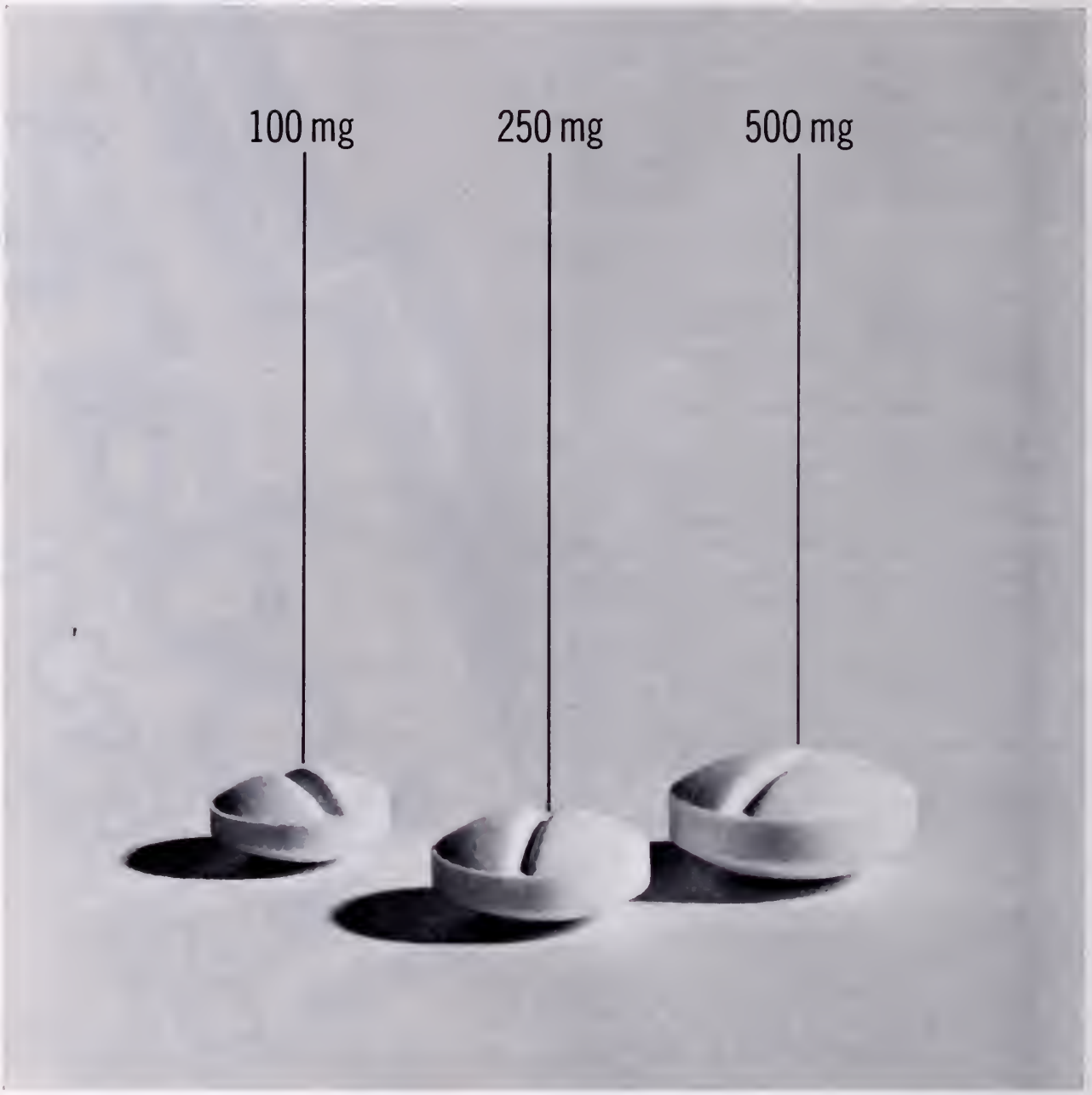
The AMA specialty sections each will present programs in 28 different medical specialties.

Special program topics will include, "Therapeutic Approaches to the Rape Victim," "Psychology-Biology Origins of Maleness and Femaleness," "Physicians' Marriages," and "Nutrition."

Medical motion picture showings will be held during the meeting. Some 100 scientific exhibits and 125 industrial exhibits will offer visual displays of new developments in medical care.

The AMA Auxiliary will hold its convention simultaneous with the AMA convention. The AMA's policy making body, the House of Delegates, will meet at the Chase-Park Plaza Hotel.





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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
May 1978, Vol. XIX, No. 5

ORIGINAL PAPERS

Blood Viscosity Determinations Directly From the Vein

VAN B. PHILPOT, JR., M.D., RUNE STJERNHOLM, Ph.D., H. J. BLAKENEY, M.D., BRUCE ATKINSON, M.D., W. T. OAKES, M.D., B. O. MOORE, M.D., PAUL WHITESIDE, M.D., CHARLES SECREST, M.D., and LEWIS BLACK, M.T.
Houston, Mississippi

A method is described whereby blood viscosity determinations can be made while the blood is being drawn from the vein. The results confirm previously reported work by Mayer and others that the viscosity of males is considerably greater than that of females. Exercise lowers blood viscosity and simultaneously increases the hematocrit. The paper also confirms previously reported results by Mayer that dicoumarol therapy decreases blood viscosity. Patients with a previous history of coronary artery disease have an increased blood viscosity. Some patients with acute myocardial infarction have a decreased blood viscosity while others have an increased blood viscosity.

THEORIES OF BLOOD viscosity have influenced the art of medicine since the time of Hippocrates and formed a theoretical basis for the practice of bleeding, purging, and blistering during the Middle Ages. Instruments are currently available for the determination of whole blood viscosity in vitro and have influenced cardiologists such as Burch[1] to recommend phlebotomy in the treatment of some patients with coronary artery disease. These methods, however, require the transfer of blood from the patient to the laboratory introducing likelihood of artifacts resulting from anticoagulants and/or the time required from the drawing of the blood to the performance of the test.[6]

The purpose of this paper is to present a method for determining the viscosity of blood as the blood is being drawn from the vein.

Materials and Methods

The viscometer consists of a 3-way channel with a disposable plastic syringe on one end, a conventional hypodermic needle on the opposite end, and a vacuum gauge in the center (see Figure 1). A blood pressure cuff around the patient's arm is inflated to 30 mm of mercury to keep the vein distended. Using the instrument just described, a venipuncture is performed in the antecubital vein and blood is withdrawn under a standard vacuum for a specified period of time. For most of the experiments presented in this paper, the vacuum was 150 mm of mercury, the time was specified as 15 seconds, and the body temperature at or near 37° C. According to Poiseuille's Law, the amount of blood drawn under these circumstances is inversely proportional to the blood viscosity.

Three different size needles were used in these experiments: a one-inch 20 gauge needle with a plastic hub, a 1.5-inch 20 gauge needle with a metal

From Philpot Memorial Laboratory, Houston, MS, Department of Biochemistry, Tulane University School of Medicine, New Orleans, Pontotoc County Hospital, Pontotoc, MS, Gilmore Memorial Hospital, Amory, MS, and Houston Hospital, Houston, MS.

hub, and a 1.5-inch 20 gauge needle with a plastic hub. These needles were standardized against distilled water at 37° C which was presumed to have a viscosity of 1. Calculations for blood viscosity were determined by dividing the quantity of distilled water withdrawn under standard conditions by the quantity of blood withdrawn using a standard needle, standard periods of time and standard vacuum.

Results

Distilled water at 37° C was removed by the syringe using 150 mm mercury for 15 seconds with the 3 different size needles. Ten consecutive determinations were made with each needle and for the last 5 determinations the needle was changed each time. Using the 1.5-inch 20 gauge needle with the metal hub, the amount of water removed ranged from 13.0 to 13.6 ml. Using the 1.5-inch 20 gauge needle with the plastic hub, the range was from 11.9 to 12.2 ml, and using the one-inch 20 gauge needle with the plastic hub, the range was from 13.0 to 13.9 ml. These results show that the method is highly reproducible since the variations with each determination are well within a limit of error of 5 per cent or less.

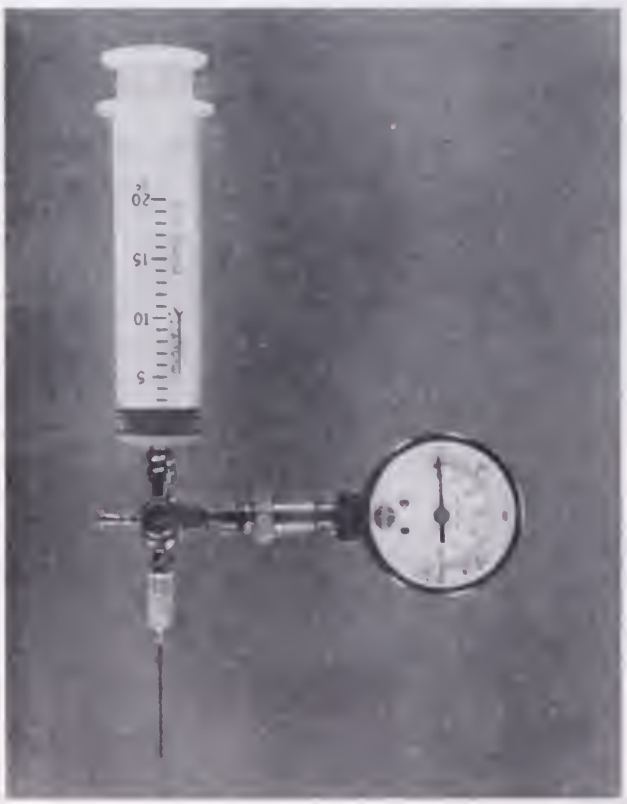


Figure 1. Blood Viscometer.

A venipuncture was performed on each arm of three normal volunteers within a few minutes of one another and blood withdrawn for 15 sec. at 150 mm Hg. There was less than a 3 per cent variation in the amount of blood drawn from the 2 consecutive determinations of each volunteer. These results show that the method has a high degree of reproducibility under test conditions.

TABLE I

BLOOD VISCOSITY* OF NORMAL ADULT VOLUNTEERS

Male	*Female*
1.88	1.52
1.65	1.60
1.88	1.45
1.88	1.48
1.80	1.46
1.76	1.48
1.85	1.48
1.69	1.48
1.85	1.45
1.76	1.48
Av. 1.80	Av. 1.48

* Figures represent ratio of volume of distilled H_2O/blood under identical conditions.

Table I shows the viscosity determinations of 10 normal male volunteers and 10 normal female volunteers. The figures represent a ratio of the volume of distilled water using standard conditions of vacuum, time, and needle size divided by the volume of blood. It can be seen from this table that the viscosity of normal male adult volunteers is considerably greater than that of female volunteers. The age of volunteers in this series ranged from 18 to 60 and there appears to be no significant difference with respect to age.

The effects of exercise on blood viscosity, hematocrit, blood pressure, and pulse rates is shown in Table II. The exercise consisted of jogging for a period of 10 to 15 minutes with an increase of the pulse rate to 120 beats per minute or greater. The results show that exercise under these conditions lowers blood viscosity. In the 3 volunteers where hematocrit was determined along with decrease in blood viscosity under these conditions, there was a simultaneous increase in the hematocrit.

Blood viscosity of patients with myocardial infarction is shown in Table III. During the convalescence and recovery phase (four weeks or longer after the initial onset of myocardial infarction), the



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Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

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One Quibron-300 capsule q6-8h yields therapeutic serum levels (10-20 mcg/ml) in many adults. With a single dose, more than 75% of patients achieved serum levels potentially providing clinical benefit (5-15 mcg/ml). Half-life of theophylline varies widely from patient to patient, making monitoring of theophylline therapy important. Patient response may be monitored clinically if blood levels are not available as long as dosage does not exceed 1200 mg in 24 hours for adults.

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The simple, convenient dosage of new Quibron-300—one capsule every six to eight hours—makes it easy for patients to comply with high-dose regimens often required to achieve therapeutic serum levels. Quibron-300 capsules may provide maximum therapeutic value with maximum convenience. In fact, the switch from a low-dose to a high-dose regimen may be accomplished by merely switching capsules, by stepping up to Quibron-300 capsules.

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Adverse reactions to theophylline are related to serum levels and are usually not a problem at concentrations below 20 mcg/ml. Of 45 patients studied[1] after a single dose, only seven reported adverse reactions. The most common reaction was a feeling of lightheadedness by three of these seven patients.

Reference 1. Data on file, Mead Johnson Pharmaceutical Division

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Quibron-300— Adults: 1 capsule every 6-8 hours.
Theophylline dosage may be cautiously increased to 2000 mg/24 hour in adults and 9 or 10 mg/kg every 6 hours in children. Monitoring of serum theophylline levels at higher dosages is recommended.
Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.
How Supplied: Quibron Elixir: Bottles of 1 pint and 1 gallon. Quibron Capsules: Bottles of 100 and 1000 and unit-dose packs of 100. Quibron-300 Capsules: Bottles of 100.

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TABLE II

EFFECT OF EXERCISE ON BLOOD VISCOSITY, HEMATOCRIT, BLOOD PRESSURE AND PULSE RATE

Volunteer	*Blood Viscosity**		*Hematocrit*		*Pulse Rate*		*Blood Pressure*	
	BEFORE EX	AFTER EX	BEFORE EX	AFTER EX	BEFORE EX	AFTER EX	BEFORE EX	AFTER EX
1 F	1.52	1.43	44	46	81	125	110/70	130/80
2 M	1.76	1.44	43	44	80	120	110/70	120/70
3 M	1.85	1.57	38	41	84	120	125/65	155/40
4 F	1.60	1.45	42	—	84	120	120/80	—
5 M	1.69	1.60	—	—	68	124	152/75	—
6 M	1.88	1.78	—	—	—	—	—	—
7 M	1.88	1.65	—	—	78	120	—	—

blood viscosity of these patients is increased. In the acute phase, however (first two weeks of illness), five of these seven patients showed a below normal blood viscosity whereas two out of the seven patients in the acute phase showed an above normal blood viscosity. It is noteworthy that both patients showing an increase in blood viscosity were not treated with anti-coagulants and both patients expired within six months. Of the five patients with a decrease in blood viscosity, only one expired.

TABLE III

BLOOD VISCOSITY OF PATIENTS WITH MYOCARDIAL INFARCT

Acute Phase		*Convalescent and Recovery Phase*	
MALE	FEMALE	MALE	FEMALE
2.8		3.70	2.12
1.48		2.0	2.44
1.53			
1.37			
1.51			
1.48			
2.0			

Normal Values

Male	*Female*
Range 1.65-1.88	Range 1.45-1.60
Av. 1.80	Av. 1.48

One patient with myocardial infarction was admitted to the hospital with a blood viscosity of 1.76 and after 18 days of coumadin therapy, the blood viscosity dropped to 1.55.

Discussion

The coagulability of blood and the settling of red cells by gravity present problems in the determination of blood viscosity in vitro. These two phenomena make the Ostwald viscometer impractical.

Dintenfass[3] has concluded "viscosity of whole blood can be measured correctly only in the rotational viscometers which are characterized by a homogeneous field shear rates and over a range of shear rates." Mayer[8] uses a capillary viscometer similar to the one described in this presentation but work was done in vitro using anti-coagulated blood.

Warren Bell (personal communication) has tried many of these standard in vitro techniques and has concluded that there is a wide range of reproducibility—up to 40 per cent. This difficulty in standardization might explain the lack of interest in whole blood viscosity by many general hospitals outside large research centers.

The method described herewith satisfies Poiseuille's Law for determining viscosity and provides standardization with a set of normal values which can be easily determined and reproduced. This method minimizes artifacts due to the change in coagulability of the blood and correlation with clinical conditions should therefore be meaningful.

This paper is a preliminary report which has paved the way for the production of a more refined instrument which will be available on a commercial basis very shortly. Work with the small instrument described herein has been discontinued for safety reasons, but it nonetheless represents the first reported attempt by man to determine blood viscosity directly from the vein.

The normal values in this presentation are considerably less than those reported elsewhere and those found in this laboratory using blood anticoagulated with EDTA. Two factors might be considered:

1. The viscosity of EDTA anticoagulated blood may be artificially higher than that found in the circulation.

2. The hydrostatic pressure of venous blood may artificially lower the viscosity in the method presently described.

Although venous pressure is not determined in this method, the artifacts of the blood pressure cuff are the same from one procedure to the next and do not appear to affect standardization.

Exercise activates fibrinolysin and lowers blood viscosity under the conditions described herewith. Consideration should therefore be given to the possibility that blood viscosity is related to the rate of fibrin formation and destruction in the peripheral circulation. The inverse relationship of blood viscosity to hematocrit in the exercise experiment is a unique observation.[1]

Mayer[8] reports that dicoumarol lowers blood viscosity in nine normal volunteers and in approximately 30 patients with myocardial infarction. From a clinical viewpoint, Mayer recommends discontinuing dicoumarol after 2 or 3 months if the effect of lowering blood viscosity is not maintained.[9] Results on one patient in our series tend to confirm the conclusion of Mayer that dicoumarol lowers blood viscosity.

Dintenfass[4] suggests that variations in blood viscosity in certain diseases may be due to the presence of an abnormal fibrinogen which differs in its physicochemical and surface-active properties from normal fibrinogen. The effect of dicoumarol on blood viscosity may be due to its action on the fibrinogen molecule.

The importance of blood viscosity has been emphasized in patients with sickle cell crisis,[2] necrotizing enterocolitis in children,[5] peripheral vascular disease and numerous other conditions.[3] ★★★

(Dr. Philpot) P.O. Box 312 (38851)

Acknowledgements

The authors are grateful for support from the Okolona Hospital, Okolona, MS, Hillcrest Hospital, Calhoun City, MS, Union County Hospital, New Albany, MS, Winston County Hospital, Louisville, MS and for useful comments by Drs. George Burch, Martin Litwin and Thorpe Ray.

The instrument was built by Gene Case of Med Lab, Inc., 2304 at 21st and Kenner, New Orleans.

An improved instrument is being manufactured by the Wescor Corporation, Logan, UT.

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May is 1978 National High Blood Pressure Month. Do your part to create awareness of the dangers of hypertension and the need for control measures. The 1978 slogan is "High Blood Pressure . . . Treat It for Life."

See your June issue of the JOURNAL MSMA for complete coverage of the 1978 Mississippi State Medical Association annual session.

Case Report XVIII of Maternal Mortality Study

W. W. WALLEY, M.D.
Waynesboro, Mississippi

THE FOLLOWING case report represents a maternal death of a 19-year-old, Gravida II, Para I, white female who died shortly after delivery of an amniotic fluid embolism to the lung.

Case No. 806

This 19-year-old, Gravida II, Para I, pregnant female at term was admitted to the delivery suite in active labor. On admission her membranes were intact and the cervix was found to be about 6 cms. dilated, completely effaced and the vertex presenting at a station +1. Her membranes were bulging and were felt to be intact. When the cervix was completely dilated she was taken to the delivery room and prepared for delivery. At this time the membranes were artificially ruptured. It was noted that the amniotic fluid was meconium stained. Fetal heart tones were stable and of good tone. As the baby's head was being delivered the patient had a tonic seizure and within a few minutes 2 grams of Magnesium Sulfate were given intravenously. Following the seizure her face became cyanotic as did the upper chest. She was immediately ventilated by the Ambu bag. The cardio-resuscitation team was called and resuscitation was immediately begun. While this was being done a 7 lb. 5 oz. male was delivered vaginally. He was described as being moderately depressed with Apgars of 5 at 1 minute and 9 at 5 minutes. The resuscitation measures given by the cardio-pulmonary team consisted of i.v. Epinephrine, Calcium Sodium Bicarbonate and Atropine. A DC defibrillation was done along with external cardiac massage but very little response was obtained. With the presumptive diagnosis of amniotic fluid embolism vs. pulmonary thromboembolism, an emergency thoracotomy was done and internal cardiac massage was given. With the chest open, defibrillization was tried again and intracardiac medications were given. The pulmonary arteries were explored for emboli but none were found. The ventricular fibrillation was refractory to all efforts and about 2 hours after delivery, resuscitation efforts were discontinued and the patient was pronounced dead.

Family practice member, Committee on Maternal and Child Care.

This is the case report of a 19-year-old white female, Gravida II, Para I, who died during delivery. The cause of death was found to be amniotic fluid embolism to the lung. The committee reviews the case, rates it as non-preventable, and discusses treatment modalities that might save some of these patients.

An autopsy was performed and gross examination showed significant pathological changes confined to the lungs. Both lungs were heavier than normal. No emboli were noted in the pulmonary arteries or their segmental branches. On cut surface the lungs were noted to be speckled throughout with 2 mm. diameter somewhat well circumcised non-elevated areas of greenish brown. There were areas that had the appearance of being "meconium" stained. Microscopically the alveolar capillaries and pulmonary arterioles were focally distended with epithelial "fetal" squames, occasional Lenugo hairs, mucin fat droplets and fibrin like material. With the small hair shafts present in pulmonary arterioles, it is certain that this material represents amniotic fluid and debris and that this patient died of pulmonary amniotic fluid embolism.

This case was reviewed anonymously by the MSMA Committee on Maternal and Child Care at a regular quarterly meeting of the committee. The committee gave it an adequacy of 5 which is the highest obtainable and listed the cause of death as an indirect obstetrical death due to amniotic fluid embolism and as such was non-preventable.

Discussion

In reviewing studies of maternal mortality, amniotic fluid embolus remains a major cause of death. A few cases of amniotic fluid embolisms will survive. Those cases who survive suggest that the patient must have immediate resuscitation and that one must adhere to general principles of good supportive care. Ventilation should be maintained with oxygen using positive pressure through an endotracheal tube if necessary and the circulation must be supportive to get an adequate tissue profusion. It may be necessary to use a vasopressor to raise the systemic pressure for this. If one is unable to detect peripheral pulses, closed cardiac massage should be begun and one must monitor the acid base status and blood gases. A definite diagnosis can be made after careful examination and if aggressive management is provided, death may be prevented.

As can be seen from this case, however, even with prompt and adequate treatment many of these patients will not survive.

Summary

A maternal death due to amniotic fluid embolus has been presented. The Committee on Maternal and Child Care indicates that amniotic fluid embolus remains a major cause of maternal deaths and discusses preventable factors. ★★★

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POSTGRADUATE CALENDAR

May 19-20, 1978
ADVANCED CARDIAC LIFE SUPPORT
PROVIDERS COURSE
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Anesthesiology and the University Medical Center Division of Continuing Health Professional Education in cooperation with the Mississippi Heart Association.

Coordinator: William W. Bradford, M.D., emergency room physician, Singing River Hospital, Pascagoula; and Thomas J. Herrin, M.D., associate professor of anesthesiology, University of Mississippi School of Medicine.

This two-day course is limited to 48 physicians who are certified by the American Heart Association in basic life support. Participants must have a thorough knowledge of external heart massage and assisted ventilation. Fee: $125.00. Credit: 12 contact hours, 1.2 CEU, Category I, AMA; AAFP; American College of Emergency Physicians.

May 25-26, 1978
NEWBORN RESUSCITATION
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Pediatrics Division of Newborn Medicine and the University Medical Center Division of Continuing Health Professional Education.

Coordinator: Gwendolyn Bussa, M.N., assistant professor of nursing, University of Mississippi School of Nursing, and instructor in obstetrics and gynecology, University of Mississippi School of Medicine.

Participants will learn more about the manual skill of resuscitation through lectures and practice sessions during this two-day course. Management of the mechanical and pharmacologic needs of the resuscitated newborn will be stressed. The course is limited to six participants. Fee: $50.00. Credit: 15 contact hours, 1.5 CEU, Category I, AMA; AAFP.

May 25-26, 1978
AGING
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Psychiatry and Human Behavior and the University Medical Center Division of Continuing Health Professional Education.

Coordinator: Edgar Draper, M.D., professor of psychiatry and human behavior and chairman of the department, University of Mississippi School of Medicine.

Counsel to Authors

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Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for up to four illustration engravings. More are not permitted unless voted on by two editors and extra costs must be absorbed by the author.

Illustrations must be numbered and cited in the text. Legends, not exceeding 40 words and preferably shorter, must accompany each illustration, typed double spaced on separate sheets. The following information should appear on a gummed label affixed to the back of each illustration: Figure number, manuscript title, author's name, and arrow indicating top of the illustration.

In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript.

Reprints may be obtained at cost plus shipping charges from the association and **should be ordered prior to publication.** The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. —*The Editors.*

Radiologic Seminar CLXXXI: Whole Body Computed Tomography In the Abdomen

SCOTT MCCAY, M.D.
Jackson, Mississippi

THE DEVELOPMENT of computerized axial tomography by Honsfield in the EMI laboratories has been called one of the most significant breakthroughs in diagnostic radiology since the discovery of x-ray by Roentgen.[1]

Computed tomography is classified as transmission radiographic scanning. The basic components of the scanning system include a ganty which encircles the part of the body to be studied; a computer which analyzes the data, and a display console for viewing and photographing the image produced. Within the ganty there is an x-ray tube which rotates around the part of the body to be scanned. A series of detectors is arranged within the ganty opposite the x-ray tube. These detectors pick up the remnant x-ray after the x-ray beam has been attenuated by body tissues. This information, which is based on attenuation of the x-ray beam by body tissues, is relayed to the computer.

The computer, utilizing the principle of modified back projection, produces a cross sectional image of the part of the body scanned. This image can then be displayed on the diagnostic console monitor and the displayed information can further be recorded for permanent display by means of photographic techniques.

Computerized tomography is superior to plain film radiography primarily due to much better contrast resolution which is approximately five times better than that of conventional radiography.

The usefulness of CT scanning of the brain has been well established. CT brain scans produce more diagnostic information than any other single study of the brain. This diagnostic modality has truly revolutionized the practice of neuroradiology.

Body scanning is a relatively new field. The early equipment had definite limitations based primarily on the length of time required for each scan. Respiratory motion and motion of the gastrointestinal tract produced artifacts which degraded the images considerably. Later developments have produced equipment with fast scanning times of 5 seconds or less; and, it is now possible to perform body scans while respiration is suspended and with virtually no motion artifacts from intestinal motility.

Now that equipment is available to produce good body scans, what is the usefulness of these studies in the abdomen?

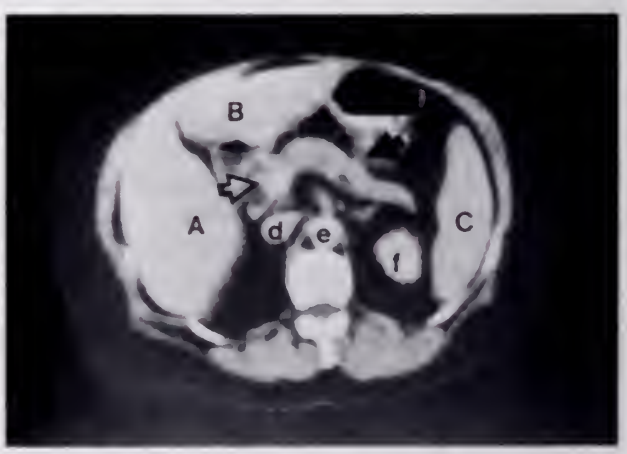


Figure 1. Normal abdominal CT scan through the level of the pancreas. Open arrow points to head of pancreas. Closed arrow points to the body and tail of the pancreas. A—right lobe of liver, B—left lobe of liver, C—spleen, D—inferior vena cava, E—aorta with superior mesenteric artery seen arising from anterior aspect of the aorta, F—upper pole of left kidney.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, St. Dominic Hospital, Jackson, MS

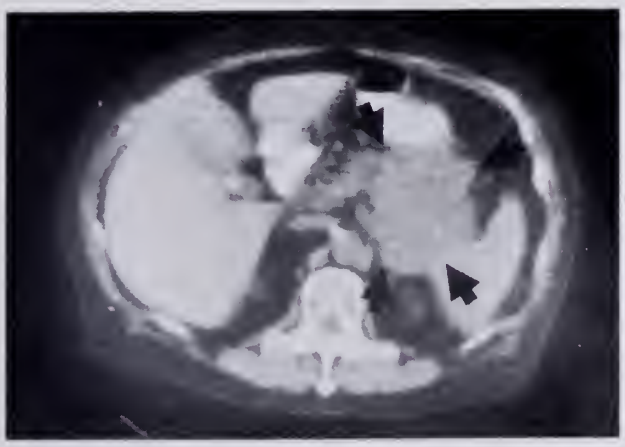


Figure 2. Mass lesion in the body and tail of pancreas representing pancreatic carcinoma.

In the abdomen, the study is of great use in investigation of mass lesions—particularly in the liver,[2] pancreas,[4, 5] kidneys and retroperitoneal space. It is also possible to obtain very useful information about intraperitoneal mass lesions such as hematomas, abscesses and mesenteric tumors. In addition to being able to determine the size of these lesions and their relationship to adjacent anatomy, one can determine whether the lesion is cystic or solid, and in the case of solid masses, information can be obtained about the tissue composition of the tumor since different tissues have different x-ray absorption characteristics. Abdominal scanning has also proved very useful in distinguishing obstructive jaundice from jaundice of hepatocellular origin; and, in staging and management of abdominal lymphoma.[3]

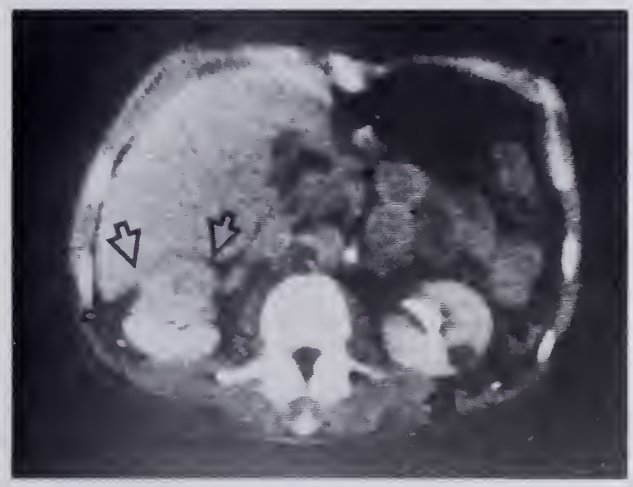


Figure 3. Section through both kidneys. The low density area in the left kidney (closed arrow) is a renal cyst. The intermediate density area in the right kidney (open arrow) is a renal cell carcinoma.



Figure 4. Section through hilar area of the liver demonstrating dilated, branching bile ducts. This pattern is diagnostic of obstructive jaundice, in this patient due to carcinoma of the head of the pancreas which was demonstrated on other sections.

Selected examples of abdominal CT scans demonstrating normal anatomy and disease are presented. These scans were done with a GE CT/T scanner. Each photograph represents a 10mm thick slice chosen from a series of slices spaced one to two centimeters apart. Scanning time for each slice was 4.8 seconds and reconstruction time for each image was about 90 seconds. ★★★

St. Dominic Hospital (39216)

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In 1978, $17,700 is the maximum amount of yearly earnings on which Social Security contributions are paid.



The President Speaking

More Controls

JAMES O. GILMORE, M.D.
Oxford, Mississippi

THIS IS MY LAST president's page and I have thoroughly enjoyed this past year as your president. Eula and I are most grateful for the hospitality and support you have extended to us. We have enjoyed seeing old friends and making new ones.

In 1962, the Kefauver Amendments to the Food and Drug Act were passed by Congress. These amendments gave the FDA control over old and new drugs used by patients.

In order for the FDA to move ahead in its control of patients, physicians, and the pharmaceutical industry, they are now proposing the "Drug Regulations Reform Act of 1978." This piece of legislation is 134 pages in length.

This bill would give the FDA direct controls over the practice of physicians and pharmacists. It would also give FDA almost unlimited authority over the drug industry. In many situations they would be prosecutor, judge, and jury.

A new drug would only be approved if proven more effective than a similar drug on the market.

The bill would further give the FDA the right to place practically any limitation they choose on the availability and use of drugs. This includes restrictions as to the setting in which the drug may be used, for what it may be prescribed, how many doses may be dispensed, how often the prescriptions may be refilled, and what the penalties will be, if any of the orders are disobeyed.

The FDA could restrict the use of drugs to hospitals of the agency's own selection for unlimited periods of time. The doctors could be required to obtain written consent from the FDA for each patient who receives the aforementioned drug.

The controls that could be placed upon physicians and pharmacists, if this bill passes, are intolerable; but they are nothing compared to the controls, regulations, and restrictions this bill would place upon the pharmaceutical industry and research.

The proposed regulations would not in any way provide more new drugs for patients, but would instead only increase costs.

I think it behooves us as practicing physicians to oppose any further restrictions on the practice of medicine.

Thanks again for a wonderful year. ★★★

EDITORIALS

JOURNAL OF THE
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MEDICAL ASSOCIATION

VOLUME XIX, NUMBER 5
MAY 1978

The Problem of Inflation

By the time this is printed, our annual session will be past history. It is my sincere hope that we will have voiced our concern about the rampant inflation that is destroying our economy and making the value and security of our savings dwindle more each day.

Everyone seems concerned, but few groups or individuals are willing to endorse any program that limits them, but readily recommend those limits for others.

It was interesting to hear our candidates for the soon-to-be-vacated Senate seat speak on the energy crisis. Most of them decried big government intervention in this problem and one even stated that we should keep Mississippi's gas and oil in Mississippi. Only one stated that he was prepared to support government control of energy if necessary.

It is very questionable in my mind whether the American public has the moral fibre to deal realistically with this problem on a voluntary basis.

If there is a place for big government, it should be here, and should deal aggressively with those two problems—problems which concern our entire nation. Our politicians seem more concerned with some possible recession during an election year than with the welfare of our country.

Certainly no one likes gasoline rationing and wage and price controls, but our government is most responsible for the inflation and is becoming increasingly responsible for the energy crisis by its lack of action. We are heading rapidly toward national bankruptcy, and it is a time for statesmen—not politicians. If we have gone on record as recommending and encouraging our members to hold their fees at the present level providing labor, industry and the government use reasonable restraint in furthering inflation by unwarranted price and wage increases, we will have shown the public that we are willing to to our share.

W. Moncure Dabney, M.D.
Editor

May Is High Blood Pressure Month

May 1978 has again been designated as National High Blood Pressure Month. MSMA is one of the organizations represented in the Mississippi Heart Association-sponsored committee to promote the month, and Dr. T. D. Lampton of Jackson is committee chairman.

The objective of High Blood Pressure Month this year is "To create public awareness of the dangers of hypertension and the need for control measures." Continuing the "Stay on Treatment" theme, the 1978 slogan is "High Blood Pressure . . . Treat It for Life."

Alarming statistics, compiled by the National Institutes of Health High Blood Pressure Education Program, show that of the people who have high blood pressure, only about 20 per cent successfully control it. Another 40 per cent do not know they have the disease. About 20 per cent are under treatment but do not yet have it under control, and 20 per cent are not treating it at all.

Graham W. Ward, coordinator of the national program, says, "We must convince and help people with high blood pressure to follow the treatment prescribed by their physicians. Too many people take their pills for a while, and then quit after a few months. They are in danger of dying prematurely or suffering disability or illness. We know that if people are under treatment for high blood pressure, they can live healthy lives."

He cites four common misconceptions which contribute to a patient's dropping therapy.

First, patients confuse controlling high blood pressure with curing it. After they reach a goal blood pressure reading, patients think they don't have to take their medication any longer. There is no cure

for the disease, but often only a pill a day will permit them to lead normal lives.

Second, according to Ward, is that many people believe high blood pressure has symptoms. Since they don't feel "sick," they don't treat the disease. He points out that most high blood pressure has no symptoms and a person can't tell when his blood pressure is up. "Once a person has the disease he will probably have it for life and must treat it every day, even though he feels great."

A third mistake is confusing hypertension with "tension." Patients who act on this error take their pills only when they feel tense or when they feel dizzy or have a headache. The pills, intended for daily use, become an occasional medication, like aspirin, for the relief of symptoms.

Fourth, Ward points out, is believing a person can choose a treatment plan. "In addition to pills, physicians sometimes prescribe that a patient lose weight, stop smoking, exercise more, and limit salt," he says. "But often the patient assumes he has a choice. Many people follow a part of their therapy and think their blood pressure is under control when it is not. In most cases, patients do not have a choice of treatment. If a doctor prescribes medication, it's just as important to take it regularly as it is to do the other things he recommends."

During High Blood Pressure Month hundreds of national and local organizations, civic and medical groups are involved in educating the general public, patients, and health professionals on the nature of the disease and its treatment. The main emphasis of this year's High Blood Pressure Month will be on convincing patients to take their pills as their physician advises. That's why, according to Ward, the slogan for May is, "High Blood Pressure . . . Treat It for Life."

The Mississippi affiliate of the American Heart Association has as its goal to screen 10,000 Mississippians during May. Pamphlets and films on hypertension are available from the MHA, 4830 East Mc-Willie Circle, Jackson 39206. . . . NG.

Medico-Legal Brief

Court Dismisses Suit by Physicians Against Patient and Attorneys

A trial court properly dismissed two physicians' malicious prosecution suit against a patient and his attorneys, the Oregon Supreme Court ruled.

The patient had filed suit against the physicians in July 1974, alleging that they had negligently administered certain drugs to him in 1972. After learning of the suit the physicians informed the patient's attorneys that they had not treated the patient during the period in question and repeatedly asked that the suit be dismissed. The action was not dismissed until January 1975.

In their suit against the patient and the attorneys, the two physicians claimed special injuries to their reputations in the amount of $50,000 and sought punitive damages of $200,000.

A second count charged negligence on the part of the patient in not informing his attorneys that the physicians had not treated him during the period in question and on the part of the attorneys in not properly investigating the case. The physicians also sought $50,000 for emotional disturbances and anguish.

A trial court ruled that the allegations did not state a cause of action, and the physicians appealed.

Reaffirming the "English rule" followed by Oregon courts in malicious prosecution cases, the Supreme Court said that the physicians' claims did not constitute the required special injury beyond the trouble, cost and other consequences normally associated with defending an unfounded legal charge. The attorneys had a statutory obligation not to counsel or maintain suits that were not legal and just.

However, the physicians' suit charged the attorneys only with negligence, not with violation of their statutory obligation. In the absence of special injuries, the allegations of negligence did not state a cause of action, the court concluded.

The lower court's decision was affirmed.—*O'Toole v. Franklin*, 569 P.2d 561 (Ore.Sup.Ct., Sept. 13. 1977)

PERSONALS

Rodolfo N. Arriola announces the opening of his office for the practice of surgery and general practice at 500 W. Main Street in Fulton.

Ross F. Bass of Jackson was guest speaker at the monthly meeting of the Central chapter, Mississippi Society of the American Association of Medical Assistants. His topic was fetal salvage.

Edward L. Carruth announces the opening of his office for family practice at St. Joseph Medical Plaza, Highway 39 North in Meridian.

Vernon Chase of Baldwyn has completed 300 hours of postgraduate work and has been named a Diplomate of the American Board of Family Practice.

Allen U. Hollis announces the opening of his office for the practice of general, chest, and vascular surgery at Suite One, Crossgates Plaza, Hwy. 80 W. in Brandon.

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1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information
ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, nor on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

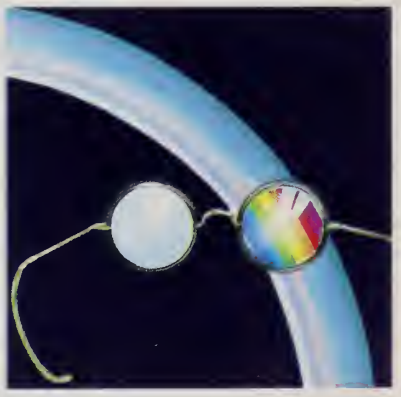
Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 25 mg t.i.d. Increase or decrease the dosage according to individual response. Daily dosage, up to 150 mg may be taken at bedtime without loss of effectiveness. Usual optimum daily dosage is 75 mg to 150 mg per day not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg, 50 mg and 100 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.



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The AMA Computer Systems in Medicine Consultative Services Program

The American Medical Association recognizes the potential that computers have in the health care setting. Therefore, the AMA has initiated the **Computer Systems in Medicine Consultative Services Program.** Through this program, physicians who are considering computer services as well as current users who want to improve or expand their computer applications can obtain an objective viewpoint and expertise in methods and equipment.

Computers have the potential to be a tremendous asset to the medical community, and have possible application in some or all of the following:

- Improving patient care
- Creating more accessible medical records
- Improving financial management and control
- Reducing the rate of increasing costs
- Improving facility and personnel utilization

The **Consultative Services Program** has established expertise extending from general decision-making on the utilization of computers in medicine to detailed systems design, programming and implementation of systems. The Program's activities include: needs analysis; alternatives development; specifications development; proposal evaluation; and systems audits.

While the major thrust of the **Consultative Services Program** will result from interest in the use of computers or computer-related services, the primary goal of the consultant is to recommend the most advantageous treatment of each situation. **The focus is the needs and objectives of the client,** not the promotion of computerized solutions.

For a more detailed description of this new and valuable service or to arrange a consultative visit, contact: John A. Guerrieri, Jr., Program Director, Consultative Services Program, at (312) 751-6417.

Mary Alice Lee of Jackson has been named a district director of the state health department. The counties in her district are Hinds, Rankin and Madison.

Robert Ashford Little of Gulfport has been elected to the Executive Board of Directors of Gulf Coast Community Hospital in Biloxi.

Myron Lockey, Ross F. Bass, Hugh P. Brown and Robert P. Henderson of Jackson have been elected medical advisors for 1978 to the Central chapter, Mississippi Society of the American Association of Medical Assistants.

S. Kimble Love of Vicksburg announces the opening of the Children's Medical Center at 920 Farmer Street.

Robert T. Love, Jr., of Greenville has been named president-elect of the American Association for Hand Surgery. Last month Dr. Love was on the faculty of a Georgetown University Hand Symposium in Washington, D. C., where he spoke on penetrating wounds to the hand.

A. Thomas McRae, Jr., announces the opening of his office for the practice of general and vascular surgery at Medical Plaza, 1002 East Madison in Houston.

Gary Nelson Morris has joined Internal Medicine Associates of Tupelo, Ltd. for the practice of internal medicine at 812 West Garfield Street.

Francis S. Morrison of Jackson and UMC lectured to the staff of the Deaconness and Welborn Hospitals in Evansville, IN during March. His subjects were modern blood component therapy and regionalization of blood services.

M. L. Patel announces that the Tunica Clinic will be open Monday through Friday.

E. J. Price, Jr., of McComb has been elected to Deposit Guaranty National Bank's McComb advisory board.

The Street Clinic of Vicksburg announces the association of Joseph H. Robinson for the practice of dermatology at 100 McAuley Drive.

G. Seale Stewart has associated with James H. Sams of Columbus for the practice of family medicine at the Family Medical Building at 321 Hospital Drive.

H. Howell Towler, Jr., announces the opening of his office for the practice of ear, nose, throat and facial plastic surgery at Okolona Community Hospital in Okolona on Mondays.

M. Ney Williams of Jackson announces his practice of general medicine with office located one mile east of Reservoir Dam on Spillway Road.

Lawrence Zaslow announces his practice of child and adult allergy at 323 Vaughn Street in Picayune.

Medical Center Adds to Faculty

Three instructors have joined the School of Medicine and centerwide faculties at the University of Mississippi Medical Center.

Dr. Norman C. Nelson, vice chancellor for health affairs, announced the appointments following Board of Trustees approval.

The new faculty members are Dr. G. Rodney Meeks, School of Medicine instructor in obstetrics and gynecology; Dr. George Ellis Abraham, II, School of Medicine instructor in family medicine; and Dr. William Robert Murphy, centerwide instructor in physiology and biophysics.

Dr. Meeks, whose appointment is effective July 15, earned the B.S. degree at Millsaps College in 1970. He earned the M.D. degree at the University of Mississippi School of Medicine in 1974. Dr. Meeks took intern and residency training at the University of Rochester Medical Center in New York.

Dr. Abraham, a B.S., M.S. and Ph.D. graduate of the University of Mississippi, earned the M.D. degree at the Medical Center in 1975. He took his residency at UMC from 1975-1978.

Dr. Murphy, a 1973 graduate of the University of Cincinnati, earned the Ph.D. degree at Indiana University School of Medicine in January.

Physicians Say There Are Enough Hospital Beds

The United States has enough hospital beds and some hospitalized patients could be treated on an outpatient basis, say a majority of physicians responding to a recent poll by the American Medical Association.

However, only about a third of those responding said some hospital beds could be eliminated without negatively affecting the quality of health care.

Nearly 60 per cent of the responding physicians said the current supply of hospital beds is "about right," nearly 16 per cent said "not enough" and just over 20 per cent said "too many."

Medical Center Sponsors Newborn Art Contest

Spotlighting the importance of perinatal care, the

University of Mississippi Medical Center Newborn Center and the March of Dimes are again sponsoring the annual newborn art competition.

More than 80 artists have entered the contest since it was initiated in 1976. It is the only competition of its kind in the South.

Artists may submit works in any medium, but all entries must reflect some aspect of maternal and infant care or the family unit. Each entry must be ready for showing and include a brief narrative of the intent of the work in relation to the competition theme.

One purchase award is offered in each general contest division: $50 in the high school category; $150 in the college and university division; $250 in the adult division; and $50 in the special photographic category. Winning entries will become part of the Newborn Center's permanent collection.

The work designated "best in show" will be used as art for the Newborn Fund benefit Christmas card in 1978.

Works will be displayed and contest winners announced at a formal showing at UMC June 25.

Deadline for the 1978 competition is June 22. There is a $2 fee for each adult entry, but no fee in the other categories. Participants may enter up to two works.

Entries may be mailed to Special Services, University Medical Center, 2500 North State Street, Jackson, MS 39216, or hand delivered between 8:00 a.m. and 5:00 p.m. June 19-22.

Hepatitis Prophylaxis Is Discussed

Hepatitis B Immune Globulin (HBIG) has been licensed by the FDA's Bureau of Biologics for use in individuals exposed to hepatitis B by accidental needle-prick, splash, or oral ingestion (pipetting accidents) involving material containing hepatitis B surface antigen, according to Dr. Durward Blakey of the State Board of Health's Bureau of Disease Control.

HBIG is approved only for the exposure situations mentioned above and not for exposure to patients with hepatitis B. Use in pre- or post-exposure situations should be restricted to well controlled clinical studies.

The recommended dose of HBIG is 0.06 ml per kilogram of body weight. The appropriate dose should be administered, intramuscularly, as soon as possible after exposure and repeated 28-30 days after exposure. Cost of prophylaxis is of concern as a 5 ml vial of HBIG currently sells for about $150, said Dr. Blakey.

Conventional immune serum globulin (ISG) should continue to be used for passive immunization of contacts to a case of hepatitis A. Hepatitis B surface antigen (HAA) testing should be done on all cases of hepatitis. This test is available at many laboratories but not from the Public Health Laboratory. A positive HAA indicates hepatitis B virus infection. Most lots of ISG have too little hepatitis B antibiody to be of much value in treating contacts to hepatitis B cases.

The Bureau of Disease Control will supply on request ISG to local health departments for the immunization of household contacts to hepatitis A, noted Dr. Blakey.

Leukemia Society Funding Is Available for Research

Applications are now being accepted by the Leukemia Society of America, Inc. for grants designed to give financial support to clinicians and basic researchers whose work is aimed at finding a cure or control of leukemia and allied diseases of the blood-forming organs.

The awards are available in three categories, according to Dr. Rose Ruth Ellison, the national health agency's Vice President for Medical and Scientific Affairs. The physician heads a 20 member group of specialists who volunteer time each year to evaluate and review all applications on a competitive basis.

A five-year scholarship for $100,000 is the most prestigious of the society's grants. It is presented to highly qualified individuals who have demonstrated their ability to conduct original scientific research bearing on leukemia and related disorders, but who have not yet attained the tenured rank of associate professor. Two year special fellowships and fellowships for $31,000 and $25,000 respectively are intended for those in the intermediate and beginning stages of career development. Regardless of category, all grantees must hold doctoral degrees and are required to concentrate on research relevant to leukemia or lymphoma. There are no restrictions as to age, race, religion or sex and candidates need not be American citizens to be eligible. Application forms may be obtained from Dr. Rose Ruth Ellison, Leukemia Society of America, Inc., 211 East 43 Street, New York, NY 10017. Deadline for completed applications is Oct. 1, 1978, with grants effective in July 1979.

MEDICAL ORGANIZATION

Senate Voids Finch's SBH Appointees

For the second straight year, but with a lot more emphasis this time, the Mississippi Senate has rejected appointees to the Mississippi State Board of Health made by Governor Cliff Finch.

Citing his personal disagreement with a statute requiring Board appointees to come from nominees submitted by MSMA, but intent to uphold the law, Senator Theo Smith, chairman of the Senate Public Health Committee, reported his committee's refusal to confirm Finch's appointees during the closing days of the recent legislature session. The committee and full Senate did confirm one Finch physician appointee to the Board, Dr. John R. Lovelace of Batesville, a MSMA nominee.

Last year the same Senate committee also refused to confirm Finch's appointees to the Board but only after a public hearing where some committee members voiced their support for the appointees.

The four Finch appointees failing to receive Senate confirmation were Drs. Howard A. Clark, Morton, William A. Middleton, Winona, Gilbert R. Mason, Biloxi and John W. Murphy, Jackson. All except Dr. Murphy were also appointed by Finch last year.

The State Board of Health controversy began in June 1976, when Finch refused to accept MSMA's nominees and directed that new nominees be named to include Drs. Middleton and Clark. When the nominees were not forthcoming, Finch stated that the law allowed him to select nominees from any "medical association" and produced a list of nominees from the predominately black Mississippi Medical and Surgical Association which included Drs. Middleton, Clark and Mason, a black physician.

Even though the legislature refused to confirm Finch's appointees in 1977, they continued to serve on the State Board of Health and MSMA went into state court with a "Quo Warrento" suit to remove them from the Board. Finch meanwhile went into federal court to have the state law governing MSMA nominees to the Board declared unconstitutional. A decision has not been rendered in either suit.

In January of this year Finch named Dr. Murphy to another vacancy on the Board and he and the other nominees attended a Board meeting which many felt was to be a "showdown" between the MSMA nominees on the Board and Finch's appointees. In a surprise move, however, Board president Dr. Moncure Dabney of Crystal Springs produced a letter from the Attorney General which in effect declared Finch's appointees null and void. Then in February, in what was one of the most peculiar aspects of the entire State Board of Health episode, the state judge who had jurisdiction over the MSMA "Quo Warrento" suit announced his retirement from the bench to enter law practice with one of Finch's legal assistants.

MSMA and MHA Announce Cost Containment Program

MSMA and the Mississippi Hospital Association have jointly announced formation of a state voluntary hospital Cost Containment Committee.

The committee, which is patterned after a national committee formed by the AMA, AHA and American Federation of Hospitals, will seek to examine the causes for increased hospital costs and ways to lessen such costs.

State committee members were chosen from government, insurance, industry, labor, consumer and medical fields and at its first meeting the committee announced voluntary goals to reduce both hospital expenditures and capital investments. Information about the voluntary cost containment program has been mailed to all hospitals in the state.

MSMA members serving on the committee are: Drs. J. Ed Hill, Hollandale; Joe Johnston, Mount Olive; Robert F. Carter, Biloxi and Robert P. Henderson, Jackson.

Medicaid/Medicare Draw Criticism

Recipients wanted more services and physicians and hospital officials complained about inadequate compensation at the first public hearing on Medicare and Medicaid conducted in Mississippi by the Health Care Financing Administration (HCFA).

The panel of state and federal Medicare and Medicaid administrators met in Gulfport last month to hear the concerns of people involved with the programs.

Recipients of the programs wanted to know why eyeglasses and dentures were not covered and why the rules governing the programs couldn't be written in plain, understandable English.

Physicians and hospital officials wanted to know why Medicare and Medicaid couldn't pay their full share of normal charges to serve recipients of the programs.

Some 300 persons, most of whom were recipients of the programs, attended the one day hearing.

Dr. A. P. Durfey, Sr. Gets 'Golden Deeds' Award

Dr. Percy Durfey, Sr., the Canton physician for over 50 years who claims he has never cured anyone, was the recipient of the Canton Exchange Club's Golden Deeds Award.

The 81-year-old Canton native accepted the award from Ross Moore, chairman of the club's awards presentations, when the group met at James' Restaurant.

Dr. Durfey, said Moore in his presentation, is titled as general practitioner but has really served the city as a specialist in many fields of medicine, including surgery, pediatrics, obstetrics and psychiatry.

"He treats the whole man," said Moore, "but he accepts no credit for healing. Dr. Durfey has always said, 'I only treat people; God heals them.' "

It is Dr. Durfey's quaint humor, said Moore, his sharp wit and his very deep concern for his patients that have endeared him so to the people of Canton. "Dr. Durfey has spent most of his life alleviating the ills and discomforts of his fellow citizens," said Moore.

Reared in Canton, the doctor was graduated from Canton High School in 1915. He was an outstanding athlete, as he was a fullback on the football team and a champion sprinter. He also played second base on the school's baseball team.

"Dr. Durfey has always liked to win," said Moore, who noted that the doctor had won the 100 yard dash in 1914 at the State High School Track Meet.

His athletic accomplishments took no second place to his academic abilities, however, and Dr. Durfey was one of the high school's outstanding students when he was graduated with honors.

He played football for the University of Mississippi, and his academic achievements also prevailed. He was a member of the "M" Club at the University, but he refused to make a speech at graduation exercises, even when an offer of "no exams" in exchange was submitted to him.

Dr. Durfey returned to Canton to set up practice over Mosby's Drug Store on Jan. 18, 1924.

He had interned for 18 months at Fairfield, AL, following graduation from Tulane Medical School. He also worked a short while at the Finkbine Lumber Company Hospital at D'Lo, before establishing his private practice here.

An additional workload was placed on Dr. Durfey the next month when he took over the duties as Madison County's Health Officer, a part-time job that offered him an extra $25 per month but no nurse to assist him.

Moore said Dr. Durfey's offices were removed from the drug store to a location next to Ring's Hardware Store on West Peace Street where they remained until the new Durfey Clinic began operation on Highway 16 several years ago.

He has been joined in his medical practice by his son Percy, Jr. His daughter Gwin often assists the doctors at the clinic.



Members of Dr. A. P. Durfey's family look on as he receives the Golden Deeds Award, the highest service honor presented by the Exchange Clubs. From left are Dr. Percy Durfey, Jr., Ross Moore of the Canton Exchange Club, Dr. Durfey, Sr., and his daughter, Mrs. Phillip Buffington. (Photo courtesy of The Madison County Herald.)

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This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

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Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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Dr. Durfey was married to the late Alice Clower of Lexington. The couple's two children gave them five grandchildren and one great grandson.

The Durfey family's ties go back many years in Canton, said Moore, as does the city's love and respect for Dr. A. P. Durfey, Sr.

"The doctor's life, which has been dedicated in service," said Moore, "has always been measured by his love for his family, his church and his fellow man."

His record of service is longer than any other Canton doctor, and is one of the longest of any man practicing medicine today.

Dr. R. M. O'Neal Named UMC Pathology Chairman

Native Mississippian Dr. Robert Munger O'Neal has been named professor of pathology and chairman of the department at the University of Mississippi Medical Center.



Dr. O'Neal

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced the appointment following approval of the Board of Trustees, Institutions of Higher Learning.

The new department head will assume his Medical Center duties July 1. Dr. Catherine G. Goetz, associate professor of pathology, is acting department chairman.

Since 1973, Dr. O'Neal has been professor of pathology and department chairman at the University of Oklahoma, chief of pathology services at University Hospital and Clinics, and pathologist at the Veterans Administration Hospital and Oklahoma Children's Memorial Hospital in Oklahoma City.

Before going to Oklahoma, he directed the Bender Hygienic Laboratory and was professor of pathology at Albany Medical College in Albany, NY. He was professor and chairman of the department at Baylor University College of Medicine in Houston from 1961-1969. From 1954-1961, Dr. O'Neal was on the teaching faculty at Washington University School of Medicine in St. Louis.

Born in Wiggins, Dr. O'Neal attended Hinds Junior College and is a 1943 graduate of the University of Mississippi. He earned the M.D. degree at the University of Tennessee College of Medicine in 1945.

Dr. O'Neal interned at Gorgas Hospital in the Canal Zone and at Baptist Hospital in Memphis. He took residency training in pathology at Baptist Hospital and in chest diseases at the Mississippi State Sanatorium. He also took postgraduate training at Massachusetts General Hospital in Boston.

An American Board of Pathology diplomate, Dr. O'Neal is associate editor of *Experimental and Molecular Pathology* and author of more than 100 scientific articles.

Dr. F. Morrison Heads National Task Force

Dr. Francis S. Morrison, professor of medicine and hematology division director at the University of Mississippi Medical Center, has been named chairman of the American Blood Commission task force on regionalization.

The task force works to improve blood services by voluntary sharing on a regional basis.

Dr. Morrison spoke at the American Blood Commission's annual meeting last month in Washington. His topic was "Regionalization of Blood Services in the United States—Past, Present and Future Relationship to the National Blood Policy."

UMC Will Graduate 147 Physicians

More than 300 health sciences students at the University of Mississippi Medical Center expect to receive degrees in 22nd annual Commencement ceremonies Sunday, May 28.

Candidates for the M.D. number 147.

Ceremonies begin at 4:00 p.m. in the Jackson City Auditorium. Keynote speaker is Dr. J. Rhodes Haverty, dean of the School of Allied Health Sciences at Georgia State University.

In addition to the M.D. degree candidates, 82 students are candidates for the B.S. in nursing; 30 for the master of nursing; 12 for the B.S. in medical record administration; 10 for the B.S. in nurse anesthesiology; 23 for the B.S. in physical therapy; eight for the Ph.D. and four for the master of combined sciences.

Chancellor Porter L. Fortune, Jr., will confer degrees.

Medical Assistants Attend Workshop

An Office Management Workshop for Mississippi medical assistants was presented Mar. 8-9 at the Coliseum Ramada Inn in Jackson. Sponsors were the Mississippi State Medical Association in cooperation with the American Medical Association and the Mississippi chapter, American Association of Medical Assistants.

Ms. Lynn Olson of the AMA Department of Practice Management, was a guest speaker. Topics covered included telephone management, medical law and the front office, medical collections and legal considerations.



Participants at the office management workshop listen to guest speaker Lynn Olson of the AMA staff.

Mississippi Physician Wins In Kodak Competition

Nine physicians, including Dr. J. Lee Owen of Jackson, MS, had the prescription for success when they entered photographs in the 1977 Kodak International Newspaper Snapshot Awards (KINSA), one of the oldest and most widely entered amateur photo competitions in the world.

Four of them won $100 special merit awards in the annual event sponsored by Eastman Kodak Company. And five won certificates of merit.

Conducted by 123 newspapers in the United States, Mexico and Canada which hold summer photography contests, KINSA attracted more than 350,000 entries in 1977.

Winning a special merit award which placed his picture among the top 220 entered was Dr. Owen, a pediatrician, who summoned his nine-year-old daughter out of candy store to pose on a stairway. "Her pensive expression may have been one of disgust," he noted.

The KINSA event annually offers $55,000 in travel and cash prizes. Among them are 200 special merit awards of $100 each, 10 honor awards of $500 each and 10 top prizes of trips for two—and spending money—to Europe, Mexico, Hawaii, the West Indies and—for the first prize winners in color and black-and-white—a month-long photo safari anywhere in the world.

The 1978 edition of KINSA will open when participating newspapers start their summer photography contests in mid-May. Anyone wishing to enter and not knowing a participating newspaper can write for details to Contest Activities Section, Corporate Information Department, Eastman Kodak Company, Rochester, NY 14650.



This is the winning photo by Dr. Owen. Having four children provides the Jackson pediatrician with a homegrown supply of usually willing photo models.

Physicians Attend UMC Surgical Forum



Dr. Richard Riley and Dr. William Thornton of Meridian, standing from left, along with Dr. Dawson B. Conerly and Dr. Charles Guice of Hattiesburg, seated from left, were among 36 physicians who received special recognition for attending all five of the University of Mississippi Medical Center's annual surgical forums. An international guest faculty lectured to more than 300 surgeons during the Mar. 9-11 seminar.

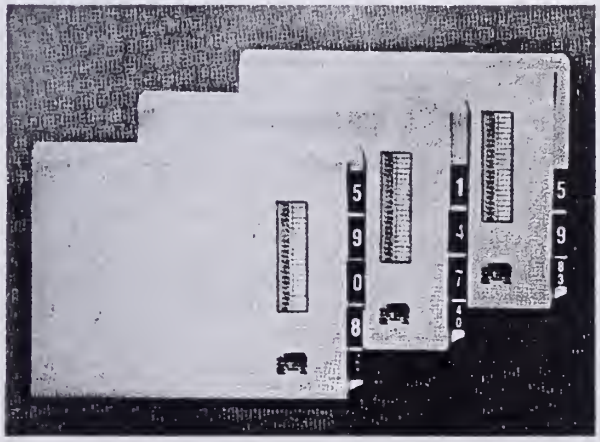
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Index to Advertisers

Air Force ... 8
AMI/Eastern Region ... 19

Burroughs Wellcome Co. ... 104B

Canton Exchange Bank ... 11
Coca-Cola ... 11
Citizens Bank and Trust Co. ... 14

Dermik Laboratories ... second cover
Doctors Needed ... 14

Harreld Chevrolet-Oldsmobile ... 16
Hill Crest Hospital ... 12

Eli Lilly and Co. ... 100A

Mead Johnson Laboratories ... 90A, 90B, 90C, 90D
Mississippi Stationery Co. ... 19

Pennwalt Corp. ... 100B, 100C
Professional Research, Inc. ... 15
Premier Printing Co. ... 16

Riverside Hospital ... 4
Roche Laboratories ... 6, 7, 108, third and fourth covers
Roerig and Co. ... 10, 10A

Smith Kline and French ... 104A

The Upjohn Co. ... 18

Warren-Teed ... 17

Thomas Yates and Co. ... 3

IN CONCLUSION

Doctors Say U.S. Has Enough Hospital Beds

Chicago, IL - The U.S. has enough hospital beds, and some patients now hospitalized could be treated on an outpatient basis, say a majority of American physicians responding to a poll of American Medical News, the weekly newspaper for physicians published by AMA. Even so, only 30% of the doctors believe that any hospital beds could be eliminated without negatively affecting the quality of health care. Sixty per cent think the current supply is "about right."

Medicaid Drug Expenditure Goes Up

Jackson, MS - Those who doubt the effectiveness of co-pay and deductibles in controlling utilization of health services paid by third parties should look at the experience of the Mississippi Medicaid Commission drug program. During the first quarter of last year with a 50¢ co-pay drug expenditures totaled $4.8 million. The first quarter of this year without the co-pay saw drug expenditures rising to $6.2 million and there were some 10,000 less persons eligible for the program.

Mandatory Insurance Requirement Upheld

Topeka, KS - A Kansas statute that requires the maintenance of medical malpractice insurance as a condition of physician licensure has been upheld by the state supreme court. The court held that "Mandatory malpractice insurance bears a rational relationship to the health and welfare of the citizens of this state by not only providing protection to patients who may be injured...but by assuring...an adequate supply of health care providers."

Laser Light Shows Will Be Regulated

Rockville, MD - HEW's Bureau of Radiological Health has been concerned about the growing use of high-powered lasers by rock groups, discotheque operators, and in the advertising industry. In order to minimize the possibility of operator and audience exposure and the associated potential for injury, the bureau recently has issued compliance guidance and established safety criteria for these lasers. The bureau has also announced that it will take action to enforce the new policies.

Most Counties Provide Alcoholism Services

Rockville, MD - The vast majority of counties across the country provide some form of alcoholism services to their residents and the organization of such services seems to indicate that counties feel alcoholism is a more serious problem than drug abuse, according to a National Association of Counties Research Foundation study. Questionnaires were sent to chief elected officials and designated alcoholism program authorities in all counties with populations of 10,000 or more.

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. Oral—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

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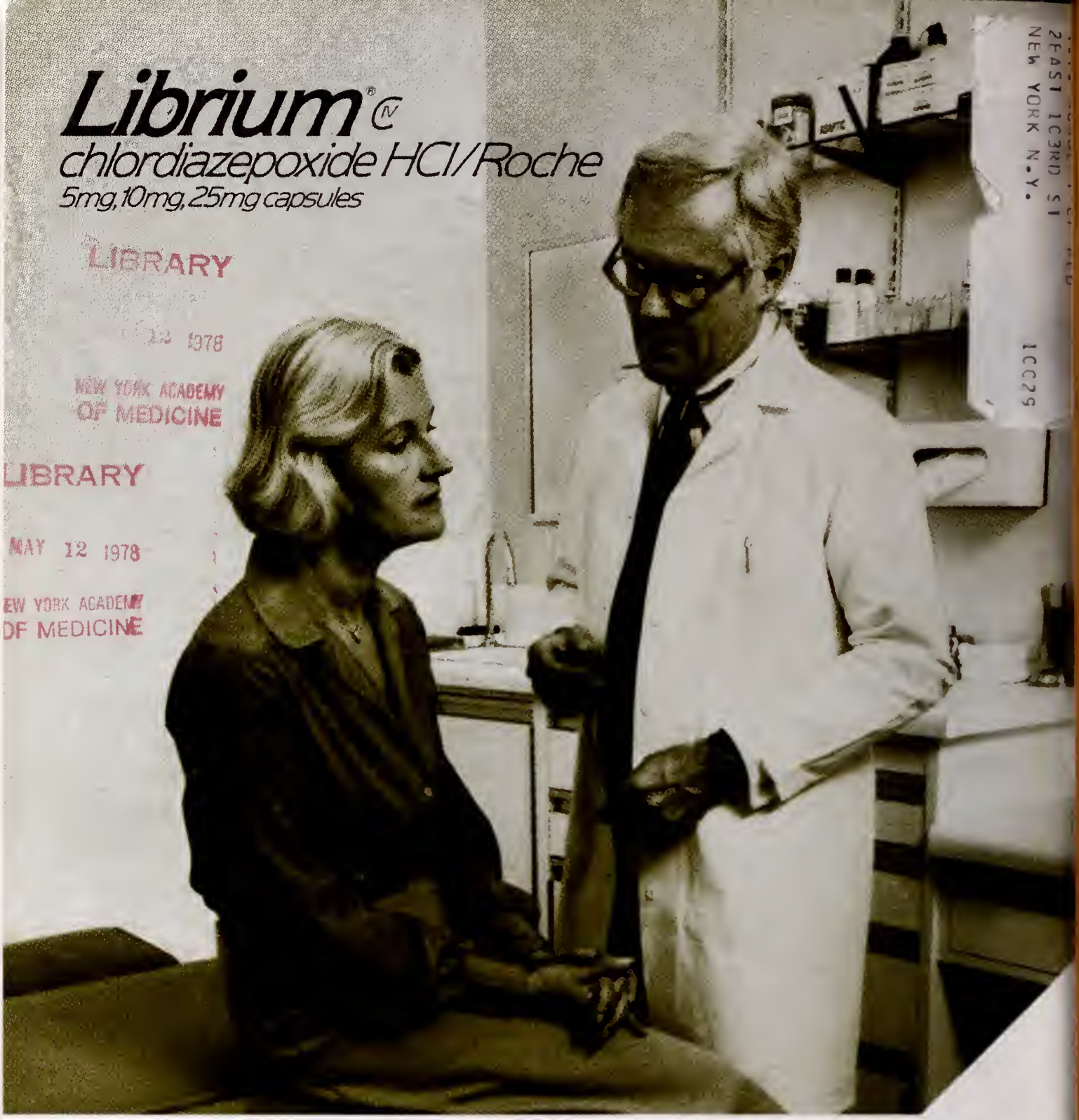
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Precautions If irritation develops, the product should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

If extensive areas are treated or if the occlusive technique is used, there will be increased systemic absorption of the corticosteroid and suitable precautions should be taken, particularly in children and infants.

Although topical steroids have not been reported to have an adverse effect on human pregnancy, the safety of their use in pregnant women has not absolutely been established. In laboratory animals, increases in incidence of fetal abnormalities have been associated with exposure of gestating females to topical corticosteroids, in some cases at rather low dosage levels. Therefore, drugs of this class should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

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The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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JOURNAL of the Mississippi
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CONTENTS

ORIGINAL PAPER

Cardiobacterium Hominis Endocarditis: A Case Report **107** George A. Pankey, M.D., and James M. Horton, M.D., New Orleans, LA

SPECIAL ARTICLES

The Physician Alcoholic— ARCH to Recovery **110** Perry R. Ayres, M.D., Worthington, OH

Radiologic Seminar CLXXXII: Ultrasound Evaluation of Some Fetal Abnormalities **114** C. D. Bouchillon, M.D., Laurel, MS

EDITORIAL

Quackery by Legislation **117** George H. Martin, M.D., Vicksburg, MS

THIS MONTH

The President Speaking **116** What Can MSMA Do for Me?

Medical Organization **121** Dr. Carl G. Evers Is Inaugurated President, Dr. Gerald P. Gable Is Named President-Elect

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Family Physicians Will Meet at Biloxi

The 30th annual scientific assembly of the Mississippi Academy of Family Physicians is set for July 12-15 at the Biloxi Hilton in Biloxi.

Special events along with scientific meetings include tennis and golf tournaments, swimming and entertainment at the president's banquet.

The program has been approved for up to 29 hours of CME credit. AAFP members are reminded to bring their yellow computer cards to the meeting, according to the MAFP president, Dr. Ralph Brock of McComb.

Registration fee is $25.00 for academy members and nonmember physicians. There is no registration fee for interns, residents, medical students and nurses.

For more information, advance programs or registration, write Mississippi Academy of Family Physicians, P.O. Box 12330, Jackson, MS 39211. Hotel reservations should be made directly with the Biloxi Hilton.

Waste in Federal Programs Is Cited

Waste, fraud and abuse accounts for more than $4.5 billion in annual losses in the federal Medicare and Medicaid programs, according to the annual report of the Inspector General's office at HEW.

The report listed $2.3 billion to $2.6 billion losses in Medicaid last year and $2.2 billion in Medicare losses as part of an overall total of $6.3 billion to $7.3 billion in all HEW programs. Money spent unnecessarily in other programs includes $669 million for Aid to Families with Dependent Children, $494 million to $1.2 billion in Income Security and other Social Security programs, $88 million for Social Services, $3.6 million from the Student Financial Aid Program, and $97 million in Aid for Disadvantaged Children education.

The Inspector General's Office was formed last year in an effort to check waste and fraud in HEW programs.



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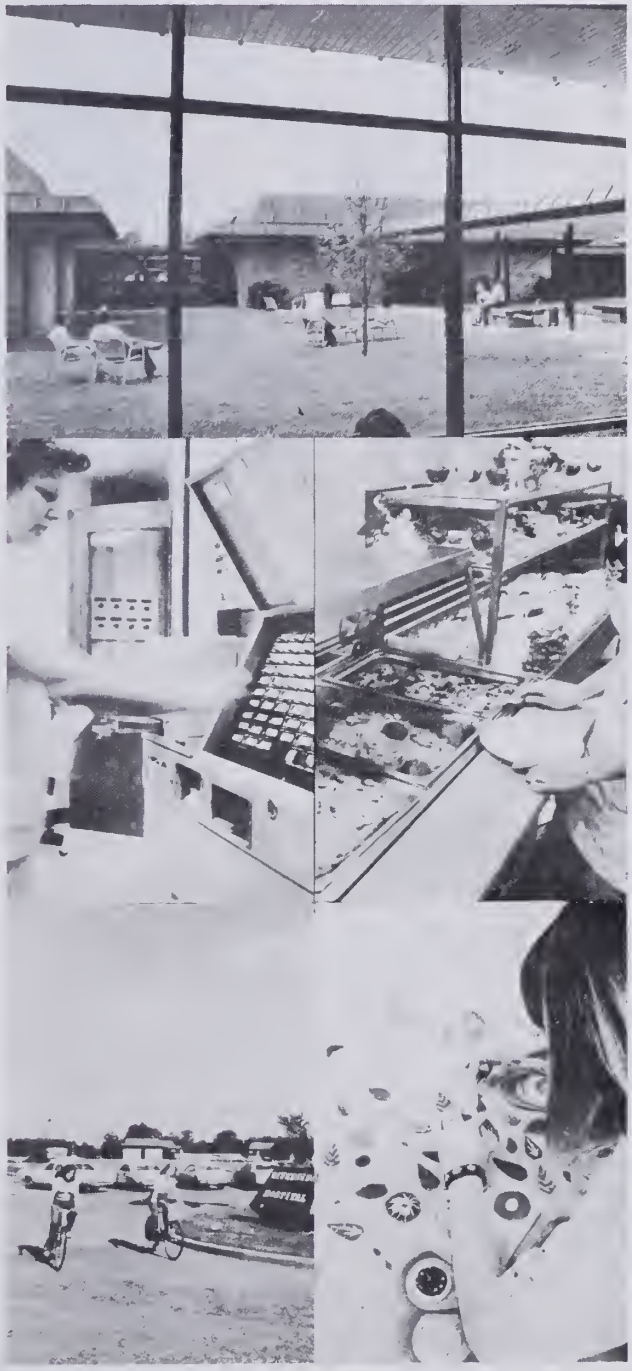
Architecturally designed to create an attractive open environment, Riverside's "non-institutional" atmosphere helps prepare the patient for specific therapy, healthy entertainment and physical recreation.

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The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

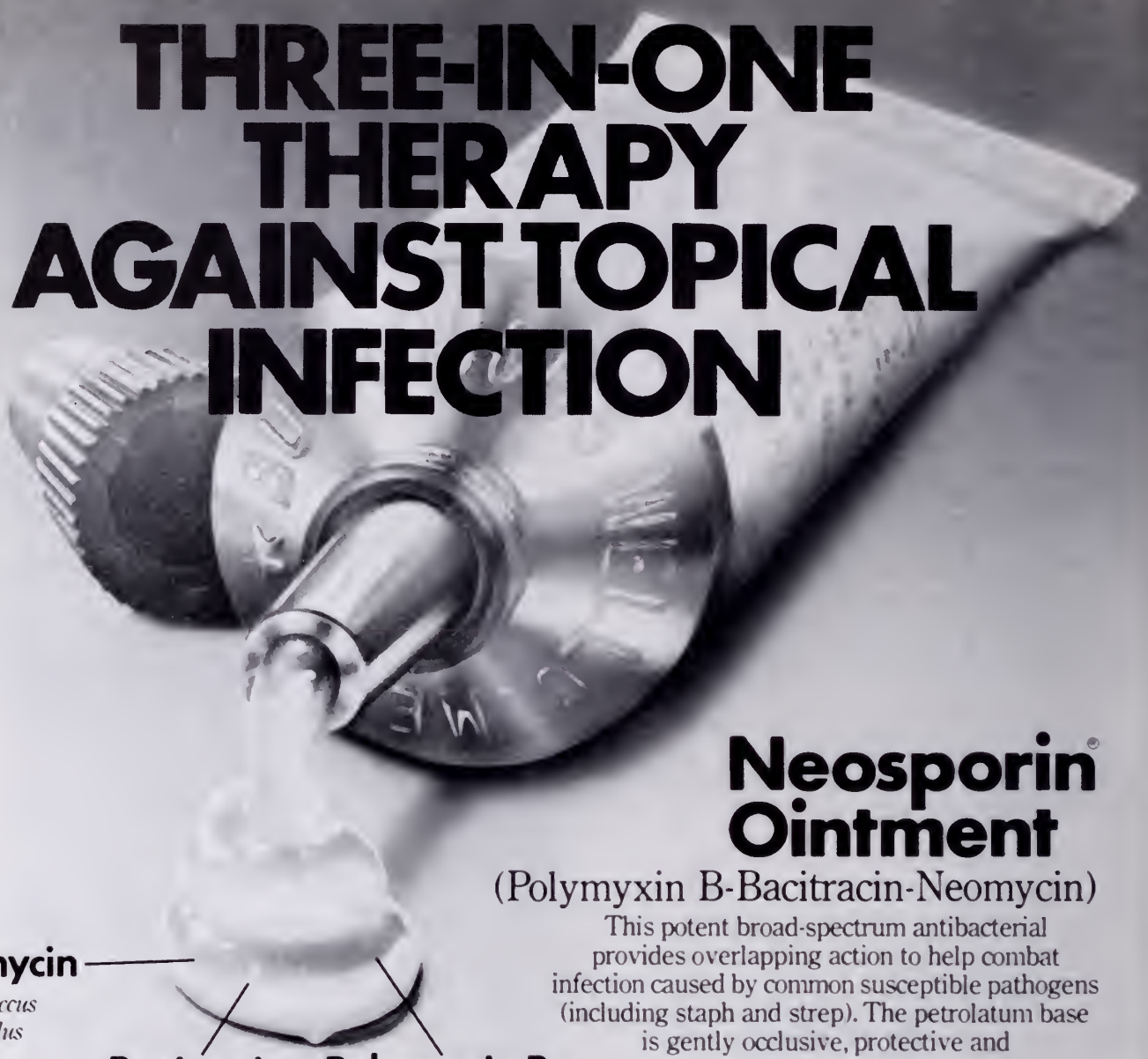
For additional information contact: John R. Reedy, Executive Director.



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PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML

NEWSLETTER

June 1978

Dear Doctor:

President Carter's recent verbal lashings of medical and legal professions has drawn adverse editorial comment. A New York Times editorial said, "We grow weary...of the President's simplistic populism." Wall Street Journal reporter wrote, "The public isn't apt to favorably respond for long to selective assaults on certain perceived villains, such as lawyers or doctors, if the Administration isn't able to effectively deal with other more acute and pressing concerns."

> One syndicated columnist called attacks "calculated populist demagoguery," and another said Carter "seemed filled with strange vapors." Tom Wicker of New York Times perhaps said it best, "Since Mr. Carter has decided to engage in tough talk...it's relevant to ask when he will direct some of it to a really important target...inflation."

The Mississippi State Medical Association and the Practice Management Division of the American Medical Association will again sponsor a series of practice management workshops for physicians' medical assistants. Information and registration forms for the workshops which will be conducted in Oxford, June 13; Jackson, June 14; and Biloxi, June 15 have been sent to all MSMA members.

MSMA president Dr. Carl Evers participated in a recent Mississippi ETV "Pro/Con program on National Health Insurance. Public hotline vote conducted after program showed 77 per cent of viewers were against (Con) a National Insurance Program. Some viewer comments were: (Pro) Man from Laurel said his wife had cancer and was insured but still had $25,000 bill to pay. (Con)"Too much government interference."

St. Paul Insurance Company has recently filed for a rate decrease in its physicians' professional liability insurance excess ($1,000,000) coverage. This is the first year since 1975 that St. Paul hasn't filed for a rate increase. Excess coverage premium is presently 100 per cent of physician's basic (100,000/300,000) coverage premium. Prior to 1975 it was 30 per cent.

MSMA's recent 110th Annual Session was one of the best attended in the history of the association. Total registration was at 869 including 536 physicians. Jackson's Coliseum Ramada Inn received many compliments on service and food from those in attendance. Mark your calendar now for next year's convention on the Gulf Coast, May 7-10, 1979.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

ACS Clinical Congress Set for San Francisco

The 64th annual Clinical Congress, the world's largest convention of surgeons, sponsored by the American College of Surgeons, will be held in San Francisco, Oct. 16-20, 1978. The college anticipates registration of 12,000 physicians for the congress, with a total attendance exceeding 22,000, including guests and members of other medical professions.

Co-headquarters for the scientific meeting will be the Fairmont Hotel and the San Francisco Hilton Hotel.

The clinical congress program will include:

- 18 postgraduate courses on a wide range of subjects, such as The Injured Patient: Management in the First 12 Hours; Gynecology and Obstetrics: Surgical Techniques; Multimodal Therapy in Cancer: Current Status and Controversies; Surgical Nutrition: Basic and Applied; Facial Skeletal Reconstruction; and The Present Status of Microsurgery.
- 270 research-in-progress reports by young investigators, known as the Forum on Fundamental Surgical Problems.
- Over 50 panel discussions and symposia on general surgery and other surgical specialties. A list of specialty sessions is attached.
- Numerous film programs, including the popular series, "Spectacular Problems in Surgery."
- A summary of "What's New in Surgery?"
- Major addresses by prominent guest lecturers, including John Lister, M.A., M.D., F.R.C.P., Postgraduate Dean, British Postgraduate Medical Federation (University of London), London, England, who will present the Martin Memorial Lecture.
- Presentation of the college's Distinguished Service Award.
- Awarding of Fellowship to more than 1,500 surgeons in convocation ceremonies on Thursday, Oct. 19, 1978. Fellowship is awarded to surgeons who have fulfilled comprehensive requirements of acceptable medical education and advanced training in general surgery or one of the other surgical specialties, and who have presented evidence of high competence, good moral character, and ethical practice.
- Honorary Fellowship, which will be awarded to distinguished surgeons from England, Japan, and Scotland.
- Installation of William A. Altemeier, M.D., FACS, Cincinnati, Ohio, as 59th president of the American College of Surgeons.

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Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Br

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e g , operating machinery, driving) Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage. withdrawal symptoms (including convulsions) reported following discontinuation of the drug

***Usage in Pregnancy*: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated) Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines Observe usual precautions in presence of impaired renal or hepatic function Paradoxical reactions reported in psychiatric patients Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax When chlordiazepoxide HCl is used alone, drowsiness ataxia, confusion may occur, especially in elderly and debilitated avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges Syncope reported in a few instances Also encountered isolated instances of skin eruptions edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy Adverse effects reported with Librax typical of anticholinergic agents, i e dryness of mouth, blurring of vision, urinary hesitancy, constipation Constipation has occurred most often when Librax therapy is combined with other spasmolytics and or low residue diets

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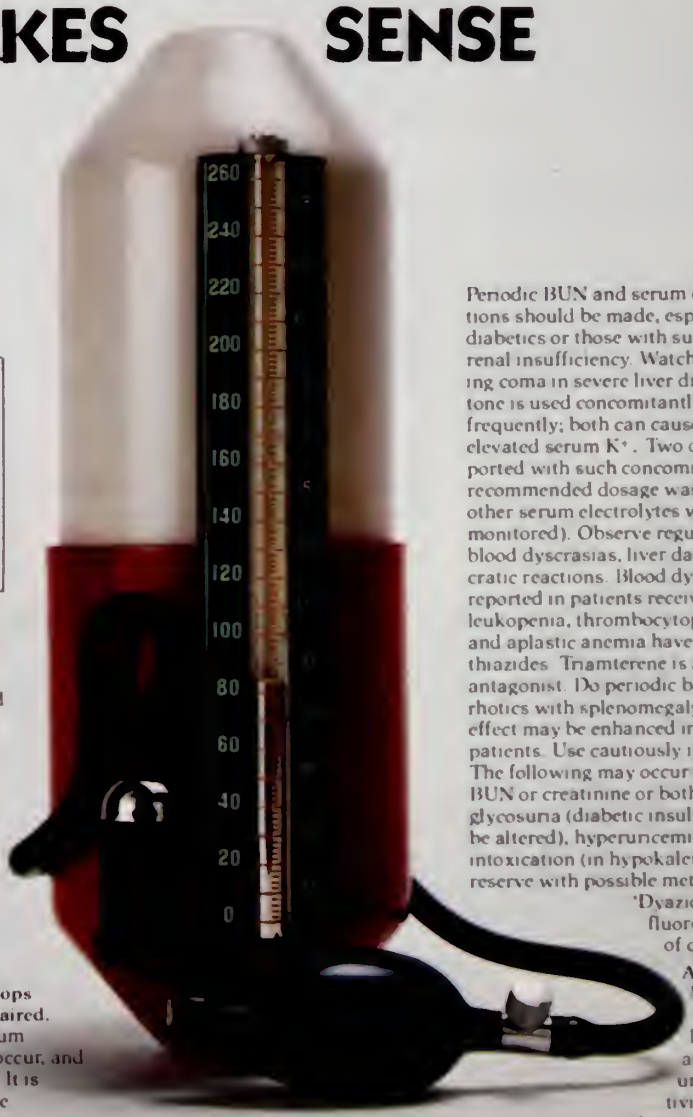
*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.

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* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions, nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone

Supplied: Bottles of 100 and 1000 capsules. Single Unit Packages of 100 (intended for institutional use only)

FOR LONG-TERM CONTROL OF HYPERTENSION:* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

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Medical Assistants Attend State Convention

Medical Assistants from across the state attended the twelfth annual convention of Medical Assistants, Mississippi Society held April 28, 29 and 30 in Greenwood. The theme for the convention was Education + Dedication = Certification.

The business session was held Saturday morning and the workshop was given by Jean Mobley, CMA-AC, AAMA, National vice-president. The workshop had been approved for 0.2 CEU credits.

There was also a tour of the historical living plantation "Florewood."

UMC Scientists Study Hypertension Drugs

A University of Mississippi Medical Center study has shown that three commonly prescribed drugs for treating hypertension had adverse effects on the offspring of rats given the drugs in combination.

The UMC scientists, with research assistant Kenneth Smith as chief investigator, gave one group of rats daily doses of reserpine, hydralazine, and chlorothiazide. The other, the control group, received no medication. All rats were pregnant; all were spontaneously hypertensive.

The drug combination did, in fact, lower blood pressure, according to Smith. After delivery, the treated rats received no medication and blood pressure levels rose again. The untreated animals retained high blood pressures before, during, and after delivery.

The offspring of the treated animals, however, were more than 65 per cent smaller than the progeny of the untreated rats. They also had smaller pituitary glands and larger hearts in proportion to their size than the untreated animals.

Smith points out that further studies will have to show the significance of the organ weight/body weight ratios.

The particular combination of drugs used by the UMC team may differ from that prescribed clinically, Smith said. And, he cautions, hypertension in rats may not exactly mimic the human disease.

Nevertheless, he said, "the present study demonstrates that drug therapy, during pregnancy, even seemingly beneficial treatment, may not be without its consequences."

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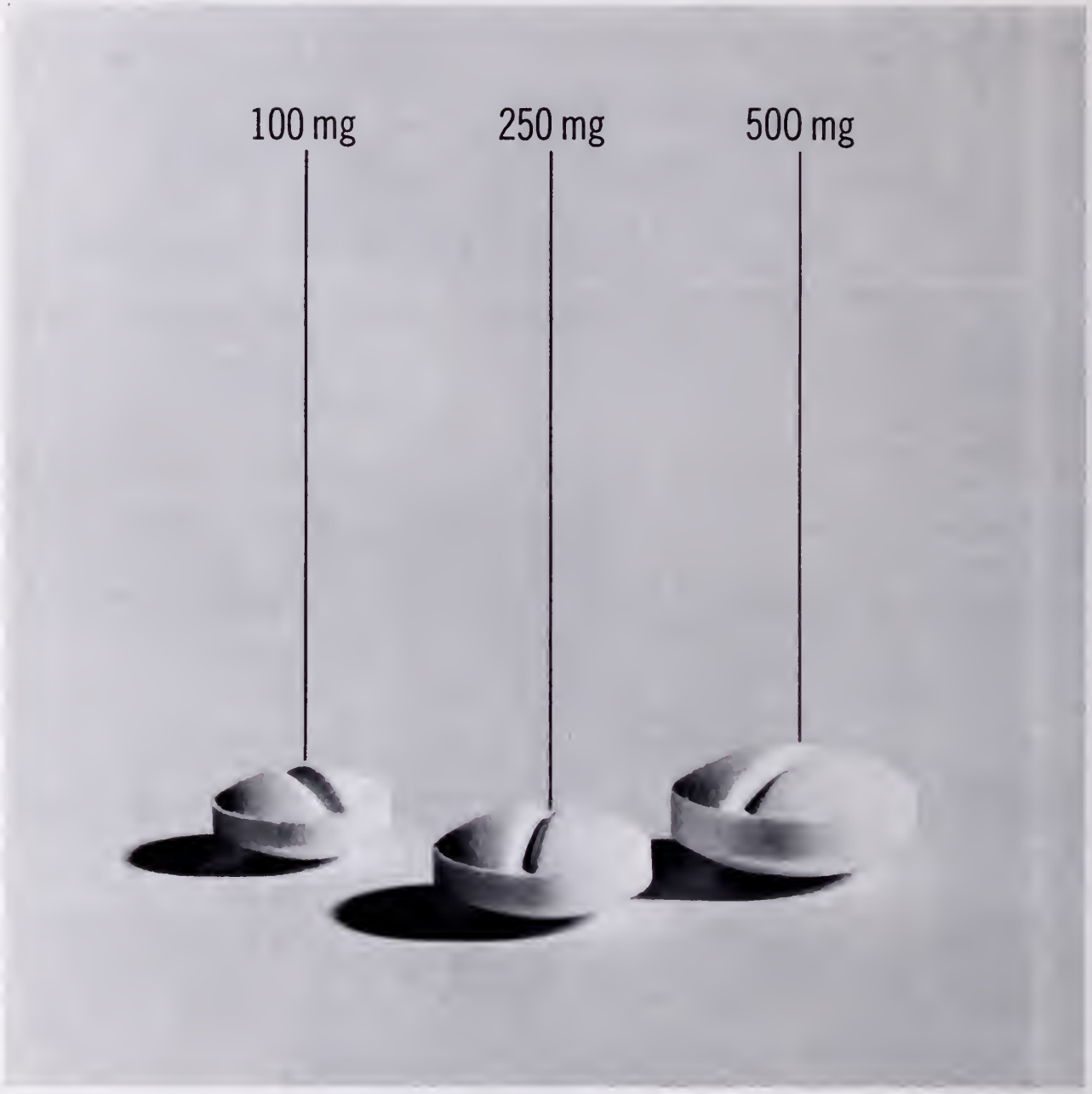
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DATELINE

Journal MSMA Receives Award

Jackson, MS - The Journal of the Mississippi State Medical Association won an honorable mention (2nd place) in the third annual Medical Journalism competition sponsored by Sandoz Pharmaceuticals of East Hanover, NJ. The Sandoz Medical Journalism Awards are for outstanding appearance and editorial qualities and journals are judged with others in their circulation categories. Journal MSMA placed second in the same award program last year. Most state medical journals entered this year.

MSMA's Membership Increased

Jackson, MS - MSMA membership continues to grow, perhaps reflecting in great part a dramatic increase in physicians locating in Mississippi during the past few years. Five-year summary of membership shows: 1972 - 1,412, members; 1973 - 1,445; 1974 - 1,502; 1975 - 1,523; 1976 - 1,549; 1977 - 1,616. MSMA membership has increased by 214 members since 1972--largest annual increase (67 new members) occurred last year (1977). Present trends indicate an even greater increase during 1978.

Television Violence Is Increasing

Philadelphia, PA - Television violence dropped sharply last year from the record high reached in 1976, according to a University of Pennsylvania Annenberg School of Communications study. The research also showed that NBC was the most violent network in the 1977 fall season, while ABC edged out CBS as the least violent. Study was partially funded by a $98,438 grant from the AMA allocated over a three year period and reviewed annually.

HEW and Hospital Cost Reductions

Washington, DC - Federation of American Hospitals has urged HEW Secretary Joseph Califano to acknowledge a downward trend in national hospital costs and to "stop the name calling and semi-hysterical criticism of nation's hospitals." FAH executive director Michael Brombert cited figures showing decrease in rate of spending by community hospitals across the country from 16.8% in January 1977 to 13.5% in January 1978. FAH, AHA and AMA are sponsoring cost cutting program called Voluntary Effort.

No NHI This Year, Says Talmadge

Washington, D.C. - Sen. Herman E. Talmadge (D-Ga.) sees no chance for a national health insurance bill to pass Congress this year. The Senate Finance Committee chairman, in an address to the Health Insurance Association of America, said, "I do not anticipate any action in the 95th Congress on national health insurance with the possible exception of consideration of coverage for catastrophic illness...The many billions of additional dollars necessary for an expanded program are just not available."

Health Costs Restraint Urged

In a major national address President Carter has urged voluntary restraint of labor and management to curb wage and price increases. Though rejecting mandatory controls for all other segments of the economy he urged passage of his hospital cost containment bill that would place a lid on hospital revenue increases.

In the immediate wake of the President's speech, Health, Education and Welfare Secretary Joseph Califano announced a number of belt-tightening measures.

The most important regulatory measure in Secretary Califano's belt-tightening list will limit Medicare payment for laboratory tests and medical equipment "to the lowest price that is widely available for the same quality in a particular community, instead of paying on the basis of average charges or even higher ones."

The initial limit will apply to the 12 most common lab tests and to hospital beds and wheelchairs purchased for Medicare patients. The limits are to be extended to other tests and equipment later.

Other initiatives announced by Califano included:

- New Medicare computer screening techniques to flag medically unnecessary health care services.
- Specific goals for length of Medicare stays and use of tests to be determined by Professional Standards Review Organizations.
- Acceleration of the program to secure second opinions in Medicare surgery cases.
- Revised regulations to encourage hospitals to pool resources and share services.
- An increase in the number of Medicare contracts put up for competitive bidding.
- A regulation to require states to give 60 days notice of any proposed increase in Medicaid fees.

Califano also said he is writing the nation's governors to ask them to promote the substitution of generic drugs and to encourage enrollment in health maintenance organizations by state employees and Medicaid beneficiaries.

Medicare Payments Are Published

The government's most recent list of Medicare payments to all physicians has been made public. But digging out the information will be tough.

HEW contends the Freedom of Information laws compel the release of the medicare data to the public. Last year, HEW issued names and payment only for physicians collecting $100,000 or more from Medicare revenues. This year, all totals, however small, of every physician who treated a Medicare patient, whether on assignment or not, will be listed.

Following the debacle of last year when the list was replete with errors, HEW and the carriers have made strenuous efforts to get the figures right this time, sending physicians in advance the totals and asking them to verify them. The project is estimated to cost about $1 million.

Some 274,000 physician's names are on the list plus nursing homes, clinics, dentists, and chiropractors, adding up to more than 300,000 entries. Only two master lists will be available—one in the office of Secretary Califano, the other at Social Security's headquarters in Baltimore, MD. The master lists—in alphabetical order—comprise volumes a number of feet thick.

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Drug Reform Bill Is Criticized

Vital decision-making authority on drug treatment of patients would be transferred from the practicing physician to bureaucrats in Washington, under legislation before Congress, the AMA has warned.

Testifying on sweeping bills to change the nation's drug laws, the AMA told Sen. Kennedy's health subcommittee that the Administration bill "improperly crosses the line which should separate the regulation of drugs to assure their safety and efficacy and the regulation of the practice of medicine through the regulation of drugs."

William C. Felch, M.D., chairman of AMA's Council on Legislation, testified that provisions in the measure "would allow medical decisions to be made by a government agency." Dr. Felch pointed to provisions allowing HEW to impose dispensing and distributing conditions on drug use; requirements for patient information labeling for nearly all drugs even against physician's recommendations; and authority for the government to decide such factors as relative efficacy in comparison with other treatment modes, intentional abuse potential and use for non-approved purposes.

"We believe that the patients of this country want their treatment decisions to be made by physicians of their choice—physicians who have the responsibility for the individual patient's care—and not by a federal bureaucracy," Dr. Felch testified.

MFMC Announces 1978-79 Board of Directors

The Mississippi Foundation for Medical Care Board of Directors has recently announced members and officers for 1978-79. They are: Drs. Whitman B. Johnson, Clarksdale, chairman; Richard C. Miller, Jackson, vice chairman; W. Joseph Burnett, Oxford; Lyne S. Gamble, Greenville; Sidney O. Graves, Jr., Natchez; J. Edward Hill, Hollandale; F. L. Lummus, Tupelo; Ellis M. Moffitt, Jackson; W. Lamar Weems, Jackson; Ray L. Wesson, Biloxi; Frank W. Bowen, Carthage; Arthur A. Derrick, Jr., Durant; Charles R. Jenkins, Laurel; David M. Owen, Hattiesburg; Jack A. Atkinson, Brookhaven; Joe M. Ross, Jr., Vicksburg; Martin McMullan, Jackson; and G. Spencer Barnes, Columbus. Others are Lewis Nobles, Ph.D., Clinton; Mr. Paul Pryor, Jackson; and Mr. Bill Carroll.

Emory Plans Conference for Teenagers

Emory University's Woodruff Medical Center will sponsor "What's Happening," the first national conference for teenagers on sex, birth control, the problems of teenage pregnancy, and other health problems of teens at Atlanta's World Congress Center June 19 and 20. Over 5,000 teenagers and adults are expected to attend from many states of the U. S.

Sexual decision-making, with emphasis on the prevention of unwanted teenage pregnancy, will be a major focus of discussion along with other health problems during the two-day symposium, according to Dr. Robert Hatcher, director of the Family Planning Program at the Emory School of Medicine and Atlanta's Grady Memorial Hospital.

Dr. Hatcher, coordinator for the conference, said that more than one million teenagers aged 15-19 become pregnant in the United States each year. In addition, some 30,000 girls under age 15 become pregnant. This means that 10 per cent of all U. S. teenagers get pregnant each year and six per cent of U. S. teenagers give birth each year. Eleven million U. S. teenage boys and girls are sexually active, he added.

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Epilepsy Council Discusses Services

Epilepsy is a word that is still shrouded in superstition and fear. As a symptom, which is as ancient as the beginnings of historical records, epilepsy has been misunderstood by society for centuries. The Mississippi Council on Epilepsy strives to erase these misconceptions and superstitions and bring an increased knowledge about epilepsy to the public. A non-profit organization, the council works to further by all proper means, the health, morale and general welfare of persons with epilepsy and to improve their social relationships. The MCE serves an estimated 50,000 epileptics in the state.

Services of the council are:

1. Information and referral
2. Speakers Bureau
3. Training for policemen and firemen in area of epilepsy.
4. Bi-monthly newsletter
5. School Alert Project—provides training for teachers in the day care centers—regular and handicapped.
6. Low cost drug program
7. Low cost insurance program
8. Advocacy and "follow along"
9. Public education programs—Annual Educational Seminar

The council office is located at 969 Lakeland Drive, Jackson, MS 39216. The telephone number is 362-2761. Mr. Gus Norwood serves as president of the council's Board of Directors.

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Ole Miss Medical Alumni Elect Officers

Dr. L. Stacy Davidson of Cleveland was installed as the 1978-79 president of the Medical Alumni Chapter of the University of Mississippi Alumni Association while Dr. Kelly S. Segars of Iuka was named chairman of the Medical Alumni Guardian Society.

Both groups had meetings in Jackson in conjunction with the annual session of the Mississippi State Medical Association April 30-May 4 at the Coliseum Ramada Inn.

Dr. J. Elmer Nix of Jackson was selected president-elect of the medical alumni, and Dr. James C. Griffin, Jr., also of Jackson, was named vice chairman of the Guardian Society.

E. Leonard Roberts, Jr., of Brookhaven received the traditional Student of the Year Award from the alumni chapter. The senior medical student is president of the Associated Student Body at the Medical Center.

Dr. Robert Lee Britt, assistant professor of pediatrics in the School of Medicine and Dr. Jim Weir, assistant professor of oral pathology/oral radiology in the School of Dentistry and UMC instructor in pathology, received the other traditional alumni awards of clinical and preclinical professors of the year respectively. Medical students select all three award recipients.



Dr. Davidson



Dr. Nix

Physicians Attend UMC Surgical Forum



Dr. Raymond Martin of Jackson, left, Dr. Jack Atkinson of Brookhaven, right, and Dr. Thomas Barnes of Greenville were among physicians from 36 states attending the University of Mississippi Medical Center's fifth annual surgical forum in March. Dr. Martin, Dr. Atkinson and Dr. Barnes were among 36 registrants recognized for participating in each of these five conferences.

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ORIGINAL PAPERS

Cardiobacterium Hominis Endocarditis: A Case Report

GEORGE A. PANKEY, M.D., and
JAMES M. HORTON, M.D.
New Orleans, Louisiana

CERTAIN UNNAMED Gram-negative bacilli have recently been reported to cause disease in man[1] but others only rarely do so. In 1962, Tucker et al[2] described four cases of human endocarditis caused by a Gram-negative organism originally categorized as "Group II-D." In 1964, Slotnick and Dougherty[3] further studied this organism's microbiological characteristics, found that it did not fit into any of the existing genera, and named it *Cardiobacterium hominis*. Between 1949 and 1973 the Center for Disease Control received only 25 bacterial isolates that proved to be *C. hominis*.[4] The following case is therefore a rare instance of endocarditis due to proven *C. hominis*.

Case Report

A 33-year-old white male truck driver had the chief complaints of weight loss, fever, and fatigue of six months' duration.

On admission the blood pressure was 130/50 mm Hg; temperature, 37.3°C; respiratory rate, 12/min; pulse rate, 110/min and regular. All pulses were of the water hammer type and equal bilaterally. Positive physical findings included a mild ptosis of the left eyelid, retinal microaneurysms and flame hemorrhages bilaterally, and one large pericapillary intraretinal hemorrhage on the left. He had poor oral hygiene with generalized gingivitis and a molar with a large cavity that was sensitive to vertical percussion.

Cardiac examination revealed an apical impulse 3 cm left of the midclavicular line, a left parasternal systolic thrill, a loud first heart sound and a soft second heart sound with an audible third heart sound, and a grade 3/6 systolic ejection murmur and a short grade 3/6 early diastolic murmur at the aortic area.

***Cardiobacterium hominis** is a slow-growing, Gram-negative bacillus that can produce endocarditis in man. It has not been reported in association with any other type of human infection and therefore must have a predilection for the endocardium. The bacillus may be identified by incubation on trypticase soy broth with carbon dioxide supplementation at 37° C. Since the Center for Disease Control received only 25 isolates that proved to be C. hominis between 1949 and 1973, this reported case is a rare instance of endocarditis due to proven C. hominis.*

The murmurs were also heard at the left sternal border radiating to the apex. The liver span was 12 cm, extending 3 cm below the costal margin at the midclavicular line. The spleen tip was palpable. He had a few petechiae on the abdomen, and splinter hemorrhages in his left second and third fingernails. There was no jugular venous distension or pedal edema, and the lungs were clear to percussion and auscultation.

The white blood cell count was 4,300/mm^3 with a differential of 66 neutrophils, 3 stabs, 70 lymphocytes, 4 monocytes, 5 eosinophils, and 2 basophils. The hemoglobin was 8.3 gm/100 ml, and the hematocrit was 25.3 per cent. Urinalysis was normal ex-

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cept for rare white blood cells and 1-3 red cells per high power field. A 12-factor automated chemical analysis (SMA-12) was normal except for an albumin of 3.1 gm/100 ml (3.5 to 5 mg/100 ml—normal values) and a calcium of 8.3 mg/100 ml (8.5 to 10.5 mg/100 ml—normal values). Rapid plasma reagin was negative. The latex factor for rheumatoid arthritis was positive at a titer of 1 : 640; erythrocyte sedimentation rate (ESR) was 128 mm/hour (Westergren), and antinuclear factor was negative. Electrocardiogram showed sinus tachycardia. An echocardiogram was interpreted as showing a vegetation on the aortic valve with aortic insufficiency, left ventricular hypertrophy, and a small pericardial effusion.

Five blood cultures grew a Gram-negative bacillus in trypticase soy broth in a 10 per cent CO_2 environment. The bacterium did not grow in a trypticase agar pour plate or in thioglycollate or Columbia broths. It was subsequently identified by the Center for Disease Control as *Cardiobacterium hominis* (see Table 1). *C. hominis* was never isolated from post-treatment blood cultures. The *C. hominis* was sensitive by the antibiotic disk diffusion method to ampicillin, carbenicillin, cephalothin, doxycycline, erythromycin, gentamicin, kanamicin, penicillin, streptomycin, and tetracycline.

TABLE 1

CHARACTERISTICS OF *CARDIOBACTERIUM HOMINIS*

Characteristic	*C. hominis**	*C. hominis From Our Patient*
Requires CO_2	+	+
Hemolysis of rabbit red cells	–	–
Temperature for growth	35-37 for maximal	37
Triple sugar iron	acid/acid	acid/acid
H_2S	–	–
Oxidase	+	+
Catalase	–	–
MacConkeys	–	–
Salmonella-Shigella	–	–
Citrate	–	–
Urea	not hydrolyzed	not hydrolyzed
Nitrate	not reduced	not reduced
Indole	+	+
Acid formation with		
glucose	+	+
mannitol	+	+
sucrose	+	+
maltose	+	+
lactose	–	–
d-xylose	–	–

* From Lennette, E. H., Spaulding, E. H., Truant, J. P.[4]

On the day of admission after the blood cultures were drawn, streptomycin (1 gm IM q 12 h) and aqueous benzyl penicillin G (5 million units in 250 ml of D_5W ½ NS IV continuous drip q 6 h) were begun. The patient became afebrile within 24 hours. On the third day after admission his carious right maxillary molar was removed with prophylactic administration of oxacillin (2 gm IV q 4 h) beginning on the day of extraction and continuing for three days.

Although the patient remained afebrile and felt well, the heart murmurs became louder, and he had increasing tachycardia. The ESR remained elevated at 109 mm/hour, and the latex fixation determination remained at 1 : 640 when repeated 22 days after admission. Cardiac catheterization performed 23 days after admission revealed a right atrial pressure of 3 mm Hg, right ventricular pressure of 25/5 mm Hg, pulmonary artery pressure of 23/15 mm Hg, and a mean pulmonary capillary wedge pressure of 10 mm Hg. The left ventricular pressure was 110/20 mm Hg, with an aortic pressure of 110/50 mm Hg. Thermodilution cardiac output was 8.1 L/min. The left ventricular cineangiogram showed good left ventricular contraction without any mitral insufficiency. There was moderate (3+) aortic regurgitation.

Twenty-four days after admission, the aortic valve was surgically replaced with a Hancock valve No. 123. The noncoronary and the left cusps of the aortic valve were found to be almost completely destroyed. Histologic sections of the valve showed atherosclerotic changes with dense hyalinization. Lipid-laden histiocytes were seen throughout the section, but no bacteria were seen. Cultures of the valve were negative. On the second postoperative day, oxacillin (1 gm IV q 4 h) was started prophylactically and continued until the patient's temperature was 37.8°C (100 F) on the fifth postoperative day. The streptomycin and penicillin were continued for all of the 34 days of hospitalization.

He was discharged improved on the eighth postoperative day. Repeated attempts to reach this patient for followup examination have been unsuccessful, although his physician in another state said he was well and working several months after discharge.

Discussion

Cardobacterium hominis, as described by Slotnick and Dougherty,[3] is a pleomorphic rod with one or both ends enlarged; it is described as Gram-negative, but some crystal violet is retained, particularly in

the end regions of the organisms. The organism is 0.5 to 0.6 μ in width and from 1.0 to 2.2 μ in length, but occasional filamentous forms 7.0 to 35.0 μ in length are seen. Sudanophilic-staining bodies are present in all strains, but granulose and acid-fast staining is negative.

The culture techniques are important because cases of endocarditis that are associated with "sterile" blood cultures may be due to failure of *C. hominis* to grow in the media being used for blood cultures or the length of time held. Subcultures on agar containing yeast extract result in growth of non-corroding colonies of uniformly Gram-negative bacilli.[5] The bacteria most likely to be confused with the nonmotile *Cardiobacterium hominis* are other slow growing Gram-negative bacilli, such as *Eikenella corrodens, Haemophilus aphrophilus,* and *Actinobacillus actinomycetecomitans*. However, *C. hominis* produces a positive oxidase reaction and characteristic sugar fermentations.

Including our patient, the 17 reported patients with *C. hominis* endocarditis consist of six women and 11 men, ranging in age from 33 to 65 years.[5-11] Most of the patients had a history of pre-existing heart murmurs, and murmurs were heard on admission in all patients. All patients reported a one to five-month history of fatigue and fever. One patient with a cerebral aneurysm presented with aphasia.[7] One patient had erythema nodosum[9] and five patients including ours had petechiae.[2, 10] All except four patients had white blood cell counts greater than 8,000/ml. Dental disease or a recent dental procedure were associated factors in several instances. The organism is sensitive to almost all antibiotics and most patients responded to a regimen of penicillin and streptomycin. Three patients died during hospitalization[2, 6, 12] and five later required valve replacements.[8, 12]

A patient reported by Laguna et al[7] had a cerebral mycotic aneurysm thought to be secondary to endocarditis due to proven *C. hominis*. Embolic phenomena were also suggested in a report by Perdue et al.[9]

With the increase in immunosuppressed patients, *C. hominis* may be expected to produce types of infection other than endocarditis. However, there has been no documentation of other types of infection. Therefore, the endocardium may present a more favorable environment for the microorganism than other parts of the body. ★★★

1514 Jefferson Highway (70121)

(Note: Dr. Horton is now at Box 1824, University of Florida, Gainesville, FL 32690.)

Acknowledgement

Cathie Dickinson provided technical assistance and Theresa Setze assisted in the preparation of the manuscript.

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JOURNAL MSMA policy limits number of references published to 10. For a complete list, write the authors.

Inflation is now the biggest public worry, reports pollster Lou Harris, with 82 to 10 people more concerned about inflation than unemployment and 73 percent expecting prices to increase at a fast or faster rate next year.

Life expectancy is lengthening according to Census Bureau report. A girl born in 1974 can be expected to live to 76, while a boy's expectancy is 68.

The Physician Alcoholic—ARCH to Recovery

PERRY R. AYRES, M.D.
Worthington, Ohio

I REMEMBER MIKE *as an outgoing, white-haired, apple-cheeked man with a boyish grin. Although we were not close friends, our paths crossed frequently, and I always felt comfortable with him. Well-trained in medicine, he kept up with current developments, served willingly and well on many hospital committees, held offices in our Academy of Medicine, and was often involved in community health activities. He had a large following of devoted patients whom he served in the best traditions of family practice. Mike was born and raised in our community, and he had a host of friends, but his social life was quiet. He was a devout Catholic and a family man who enjoyed attending church affairs with his wife and their several children. He was very well thought of by one and all.*

Mike died when he was about 50 years old and was buried with quiet ceremony. There was no public announcement of the cause of death. Some time later, however, we were shocked to learn that he was alcoholic and had died of barbiturate overdose, possibly suicidal. Only then did bits and pieces of information from the last year or two begin to have meaning. I had seen very little of Mike for several months before he died. On a few brief encounters, he had seemed tired and less ebullient than usual and had fussed uncharacteristically about the stresses of his practice. He had failed to show up for several meetings and had declined a couple of committee assignments. There had been rumors that one of his sons was having adjustment problems, and his favorite daughter was entering a convent. His previously slender, vivacious wife had gained a lot of weight and appeared anxious and depressed. Some of his old patients complained of difficulty reaching him and of his curt behavior. Much later, a nurse told of an unintelligible, nocturnal conversation with him when she called to verify an order. In retrospect, it was clear that Mike had been in serious trouble for many months. We learned that he had neither sought nor been offered assistance by his colleagues—and we were very sad.

Now, I don't know why Mike was alcoholic, but I do know that he was not a "bad" man. He was a sick man, and his sickness had profound effects upon those nearest and dearest to him and carried the potential for danger to his patients. Compounding the tragedy is the sad fact that neither he nor we could recognize the clues to his illness that are so clear in retrospect. Had it been otherwise, this fine man might have been offered treatment.

Mike's story is a composite of several physicians I have known or attended. It might have been about meperidine, barbiturate, or amphetamine addiction, or some combination of these. Perhaps it should have included, "I know I've got a problem, but I like my problem," a statement recently made to his distraught wife by a prominent colleague who is still courting disaster with alcohol and amphetamines. It might have been the story of a young man whose drug abuse began while he was in medical school and continued for years before disaster struck. It might have been about the anesthesiologist, who combined her medical career with that of wife and mother until her alcoholism destroyed both careers. Or about the small-town practitioner, whose colleagues, in the pressure of their own busy lives, covered for him during frequent unexplained absences thus unwittingly enabling his addiction to progress. Or the pathologist functioning well in his hospital job by day, who drank himself into a stupor in the seclusion of his study every night for years, and whose problem surfaced only after his wife suffered a psychotic breakdown. The futile efforts of family and colleagues might have been mentioned as in the case of the unemployed and unemployable industrial physician, whose wasted and scarred body was found in a motel surrounded by an assortment of syringes, bottles, and vials after he disappeared from a hospital during his twelfth admission for problems related to his addiction.

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Mike's story could have included a confrontation by a committee of concerned colleagues, apprising him of his difficulty and urging that he seek treatment. Or, it might have included a confrontation followed by kind-but-firm insistence that he take a leave of absence from his practice, undertake a prescribed program of treatment and rehabilitation, and then seek permission to resume practice. Just possibly, the ending might have been a happy one.

Industrial alcoholism programs feature just such confrontation. Employees are apprised of their work records and are then given firmly limited options—be fired or seek treatment. Large numbers of valuable employees are being salvaged, not to mention benefits in terms of morbidity, mortality, and quality of the lives of employees and their families.

Several state medical societies[1, 2] have launched ambitious programs for dealing with physicians impaired by addiction to alcohol and other drugs. Their aim is to protect his patients and himself while the physician seeks treatment and proves he is stable. Such programs can and must work, and the scope of their activities will enlarge as they prove effectiveness.

Volunteers performing the field work of the programs need talents of a sort that are difficult to teach —empathy, wisdom, patience, and faith. They especially need the wholehearted support of their colleagues. It is time that every physician take a fresh look at the problem of the impaired physician and start by re-examining his attitudes, for it has been said that "the attitude is the father of the action."[3]

ARCH

Performance of a physician can be impaired by many things—by senility, by ineptitude, by incompetence, by dishonesty, for example, but those accessible to treatment are psychiatric disorders, drug addiction, and alcoholism. It is the latter two that are mentioned most often, and it is the alcoholic physician who is most readily identified. The remainder of this paper will be limited to consideration of some principles and attitudes I consider essential to the treatment of alcoholic patients, although some have wider application. They are represented by the acronym ARCH for *Acceptance, Recognition, Confrontation, and Hope.*

Acceptance of the concept that alcoholism is a treatable disease does not come easily to some physicians. Although practical experience of Alcoholics Anonymous and of alcoholism rehabilitation facilities teaches us that acceptance of the disease concept by both patient and therapist is a major factor in restoring patients to sobriety and to function, there have been two major obstacles for many physicians. First is the traditional moralistic stance, which says "while man may be the victim of his vices, he is also their author."[4] No doubt. But this begs the issue. While it may say something about drinking, it says little about alcohol*ism* or about the fact that only about 10 per cent of Americans who drink develop "preoccupation with alcohol," as described in the American Medical Association definition,[5] and follow a fairly predictable course in terms of compulsion, progression, relapse, and unmanageability of their lives. The alcoholic patient is a *sick* man trying to get *well,* not a *bad* man trying to get *good.*

The other stumbling block is the notion that alcoholism is simply a symptom of underlying psychologic problems and that correction of these will remove the need for the alcoholic to drink. No doubt there are underlying problems, but this thesis disregards abundant evidence to the effect that the problems cannot be efficiently attacked until the preoccupation with alcohol is controlled, and that the problems may be resolved in the process.

Regardless of how alcoholism begins or what sort of person the alcoholic was before, it is important to recognize that alcoholism produces, in a sense, a different person—a distortion of the original. The real person cannot be perceived by himself or by others until and unless he has been released from the effects of the drug and from preoccupation with its use.

Read Mike's story again.

Recognition of alcoholism requires high levels of suspicion and empathy as well as awareness of the fact that it disrupts every aspect of the patient's life and usually of those close to him. The alcoholic and his family frequently don't recognize alcoholism as the cause of increasing problems in their lives, and they seek help reluctantly and late when they do. This is especially true of physician alcoholics and their families. Alcoholism is a stigmatized disease.

Mechanisms are available for identifying the physician alcoholic through impaired professional performance, but such impairment often is not evident until late in his course. Long before this, his family and close friends have known he was in trouble. Not being aware of the inevitable and relentless progression of his disease, fearing disgrace and financial disaster that might result from disclosure, and just simply hoping it will all work out, they keep silent and their sickness progresses along with his.

Physicians sometimes treat patients without considering the fact that alcoholism may be causing or contributing to the hyperlipidemia, the obstructive

pulmonary disease, the depression, the paranoia, for example. Furthermore, behavioral manifestations, often obnoxious and deceitful, are difficult to comprehend as symptoms of a potentially fatal disease; they may even cause us to reject the patient. We tend to overlook alcoholism even though its effects—physical, psychological, social, and spiritual—are quite evident. A syndrome is identifiable. "What causes problems is a problem.[3]

Mike's story is replete with clues.

Confrontation of the patient with the facts of his illness requires an attitude of firm kindness, sometimes called "tough love." Principles and procedures have been spelled out admirably by Maxwell[6] and Johnson,[7] and their books, although not available in most medical libraries, are highly recommended reading for anyone contemplating such an endeavor.

The object of confrontation is to overcome the arrogance and the powerful denial mechanism operating in the alcoholic by bringing him "messages from reality."[6] Then, he may become receptive to treatment. Here is where empathy, wisdom, patience, and faith are put to the test. We may fail and it may be necessary to repeat the confrontation again and again until that time when the unmanageability of his life is so painful that he will surrender and comply. Meanwhile, he and his family probably will suffer a great deal, and he may well die by suicide, by accident, or by the late effects of alcoholism before ever letting go of his compulsion. Alcoholism is a fatal disease, make no mistake about that.

When the physician alcoholic has progressed to the point where professional competence is impaired and this has been recognized by his peers, confrontation can proceed along lines similar to those used by industry, and he can be led or forced into treatment. He is faced with the reality of his unmanageability, is presented with firmly limited options, and is made responsible for his choice. This is not to say that he always accepts the evidence, even when it is overwhelming (that is part of his sickness), or that he always accepts treatment.

It is important that evidence presented at confrontation be as factual and explicit as possible. General references to "impaired performance," "work not up to your (or our) usual standard," and other faults may be challenged in the manner of that old barroom cliche, "I can whip you with one hand behind my back!" Such is the nature and power of the denial mechanism so characteristic of this disease that some physician alcoholics threaten legal action against their "persecutors," not recognizing their own vulnerability to legal action by the State Medical Board. This is reminiscent of that other barroom challenge, "I dare you to step outside and say that." Some may reject confrontation and treatment by simply retiring, moving to another state, or going into a type of work where peer approval and medical licensure are not essential—and by continuing to drink. Such hazards and disappointments should not deter us. At least, we tried.

Of course, it would be far better if family and friends, who almost always know of the problem before professional competence is affected, could become sufficiently informed and so resolute that they would initiate confrontation earlier in the hope of saving the physician, themselves, and perhaps his patients from disaster. The Auxiliaries of our Academies of Medicine would be well advised to launch an educational program for this purpose.

Mike was not confronted.

Hope must be transmitted to the alcoholic beginning with the moment of confrontation and must be shared by those confronting and attending him. For a long time before he became aware, or was made aware, that he was out of control, the alcoholic was existing in a state of lonely, anxious, confused, and fearful isolation from which the only escape he knew was by way of the depressant drug, alcohol. Dimly aware of his chaotic life, he felt the pain of guilt, but the only way he could tolerate this was to exchange it for the paranoia of resentment by heaping blame on everyone and everything handy. To recognize the role of his drinking would mean he must abstain, and this he could not do. If he tried another way out, it was probably by suicide or by self-administration of some other depressant (easily and commonly done by physician alcoholics). If he asked for help, it was for relief of his agitated depression, and he spoke of past and current stresses and of the pressures of his work and his family life. He certainly did not tell the truth about his drinking, if indeed he was aware of the truth. And he drank again. He tried changing jobs, changing residence, even changing wives, but he could not see the necessity to change himself. And he continued to drink. And the chaos was compounded.

Now, it has been spelled out to him that he is a man out of control, and he is expected to stop drinking and to regain control. He is either angry, devastated, or, sometimes, grateful. He is uncertain and confused about what lies ahead, about what is meant by treatment, by recovery. Remember, he has been isolating himself in an oppressive sort of fantasy

world. What is so clear to us about his chaotic life is not at all clear to him. If he has been thinking about his problems at all, it has been in terms of ridding himself of external pressures, not of changing himself. Now, he is faced with reality and the challenge to look at himself and to take responsibility for his reactions, his behavior. The notion that his abuse of alcohol and/or other drugs is an illness has probably not occurred to him before, and he may feel both frightened and relieved by it. Even the idea that others can and will help him may be perceived as a threat.

Little good will come of simply advising him to seek treatment. If he were capable of making good judgments and reliable decisions, it would not have been necessary to confront him. *We* must know that he can have a better life, *we* must know what proper treatment is, and *we* must know where it can be obtained. Then, *we* must take him there. Once there, willingly or by coercion, he has a chance for recovery—hope. Alcoholism is a treatable disease.

But Mike died. ★★★

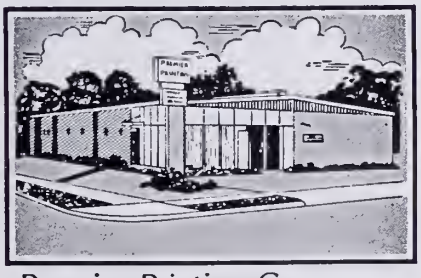
445 East Granville Road (43085)

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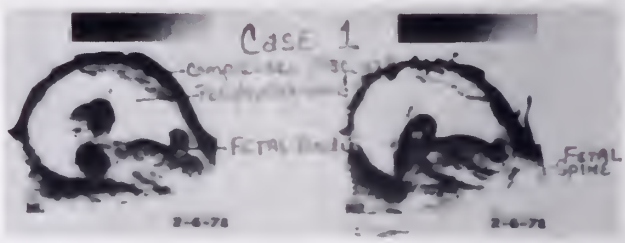
Radiologic Seminar CLXXXII: Ultrasound Evaluation of Some Fetal Abnormalities

C. D. BOUCHILLON, M.D.
Laurel, Mississippi

AFTER THE FIRST 12 weeks of pregnancy ultrasound examination has proved to be a useful method of monitoring the morphologic growth and development of the fetus in order to determine developmental abnormalities. The clinician, by combining the ultrasound findings with the endocrinologic data and the study of amniotic fluid and cells, may accurately assess the situation and instigate appropriate therapy.

Among the fetal abnormalities diagnosed with ultrasound are absent limbs; CNA abnormalities-hydrocephaly, anencephaly, microcephaly, large encephaloceles and myeloceles; fluid distentions in the fetal abdomen such as ovarian cysts, ascites, and urinary obstruction with dilatation. It is particularly helpful in the evaluation of "risk mothers" who have diabetes or Rh problems, or who have previously had a genetically abnormal baby. Two cases are presented here.

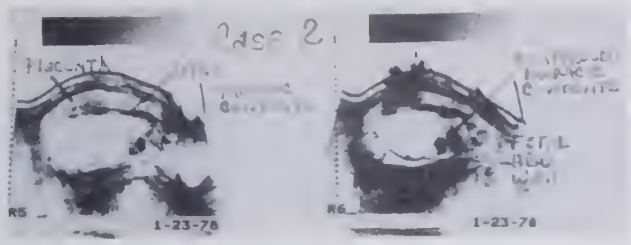
The first case, a 25-year-old white female, was referred because she was, "big for age." Ultrasound showed a single fetus with a normal sized body but the skull was absent. Normally the fetal head is the same diameter as the fetal thorax, and quite obvious on the ultrasound. The large sonolucency around the fetus indicates polyhydramnios—a frequent finding with anencephaly, and this was compressing the placenta. It is possible with ultrasound to detect anencephaly as early as 14 weeks and this may be confirmed with assay of the amniotic alpha fetal protein (AFP), which is elevated most prominently between 14 and 17 weeks. Early termination of these pregnancies may be less emotionally traumatic to the parents than continuance of such a gestation. (See Fig. 1 & 2.)



Figures 1 and 2. Anencephaly. The body of the fetus is well seen on this sonogram section, but the usually obvious rounded fetal skull was absent.

The second patient was referred for routine ultrasound examination without any expected problems. The biparietal diameter of 32 millimeters indicated a fetal age of 16 weeks which was compatible with the menstrual history and physical examination. The fetal heart pulsations looked normal. There did, however, appear to be excessive fluid present in the uterus, but we were not sure at that time whether it was simply polyhydramnios or if it was a distended fetal abdomen. Repeat examination, however, at 2 week intervals showed this fluid to be definitely within the fetal abdomen, and increasing. A few weeks later the patient was hospitalized with toxemia which did not respond to conservative treatment. At that time the biparietal diameter measured 68 millimeters indicating 28 weeks pregnancy and normal growth of the skull. The fetal abdomen, however, at this time was tremendously distended and obviously was compressing the thoracic contents. The pregnancy was terminated and the mother's toxemia promptly responded. (See Fig. 3 & 4.)

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Jones County Community Hospital.



Figures 3 and 4. Distended urinary bladder with thoracic hypoplasia. The extreme sonolucency of the fetal abdomen indicates fluid. The fetal thorax, which is normally the size of the skull, is seen to be hypoplastic.

At autopsy, multiple fetal abnormalities were found. The primary abnormality, however, was an imperforate urethra (and anus) with a very gross dilatation of the urinary bladder. Competent ureterovesical valves apparently had prevented dilation of the ureters and kidneys. The marked hypoplasia of the thoracic contents and hypoplasia of the anterior abdominal wall was considered to be secondary to pressure from the tremendous bladder distention.

The clinical decision to terminate pregnancy was made much easier by the ultrasonic evidence of gross fetal abnormality.

The safety and simplicity of the ultrasound examination, along with the rapid technical improvements now being made in imaging equipment, should be of increasing benefit to the clinician in obstetrical care. ★★★

Jones County Community Hospital (39440)

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1. Fundamentals of Abdominal and Pelvic Ultrasonography; Leopold and Archer.

2. Ultrasonography in Obstetrics and Gynecology; Sanders and James.

AMA Annual Meeting
June 17-21, 1978
St. Louis



The President Speaking

What Can MSMA Do for Me?

CARL G. EVERS, M.D.
Jackson, Mississippi

Jan and I wish to sincerely thank you for the many courtesies and offers of assistance we received at the recent 110th Annual Session of our association. It was a good and constructive meeting, with the results listed in the recent Blue Sheet and this issue of the JOURNAL. We look forward to meeting most of you and serving you during the upcoming year.

One of the more significant actions of the annual session was the approval of recommendations from the Board of Trustees and the Council on Medical Service that we formulate a state health plan which would particularly address issues which are currently of such great concern to Mississippians—those of cost, access, and quality of medical care in this state. Believing deeply in the premise that the medical profession is the most qualified to propose solutions to these issues and recognizing the great talents and wisdom that lie within the members of the Mississippi State Medical Association, I would join with Dr. James Gilmore, past president and Dr. Robert Caldwell, Chairman of the Board of Trustees, in urging that formulation of a state health plan for Mississippians be accomplished.

When one considers that the most reliable public opinion polls have established that people have more confidence in the medical profession than in any other group of professionals and that 88% of American people are satisfied with their own individual health care, we have an excellent position of strength and creditability with which to put forth our recommendations. Although the results may not be considered to be quite such a valid sampling as these national opinion polls, the results of the recent pro-con debate regarding the issue of national health insurance on Mississippi ETV further substantiate these impressions in that 77% of Mississippians responding voted against the principle of national health insurance. Let us use this confidence the public has in us to help them and the medical profession.

This is where MSMA members can make individual contributions. During the next year, a committee will be appointed with a charge to seek input and advice from the membership to formulate such a plan. There are a number of areas, such as health manpower, public health, maternal and newborn care, emergency medical services, and others where we can offer constructive, *realistic* suggestions for a long term plan of action. With such a plan we can, with more confidence and credibility, approach our legislative efforts, the Health Planning and Resources Development Act, and all other areas where MSMA interacts with others.

We will be asking you to answer the first part of the question, "What can MSMA do for me?" It can only do as much as you are willing to do for it. ★★★

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XIX, Number 6
JUNE 1978

EDITORIALS

Quackery by Legislation

The freedoms of physicians and hospitals are being progressively shackled by federal edicts, meanwhile quackery is being aided, encouraged, and even legislated by our own government. Chiropractic is recognized by Medicare and the Department of Labor and Industry. The Federal Trade Commission has ruled against the profession's ban on advertising so that phony nutritionists, acupuncturists, naturopathists, sexologists, and unscrupulous cosmetic surgeons may advertise at will.

The state legislators and the courts have ignored the counselling by the medical profession and have virtually mandated the use of laetrile. Medical schools are being forced to accept substandard students and foreign graduates by threat of withholding federal funds. Meanwhile the medical profession is being accused of conspiracy to set fees so as to gouge the public and eliminate competition.

Our only hope is to stand firm and resist what we know is unethical. Surely what is right will prevail, but sometimes we wonder.

GEORGE H. MARTIN, M.D.
Associate Editor

POSTGRADUATE CALENDAR

FUTURE CALENDAR

Sept. 21-22, 1978
ALLERGY CONFERENCE FOR PHYSICIANS
University Medical Center, Jackson

All continuing education correspondence should be addressed to: Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216.

NEW MEMBERS

BAILEY, JOSEPH N., III, Tupelo. Born Grenada, MS, Jan. 3, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned NW Memorial Hospital, Chicago, IL, July 1972-June 1973; residency in internal medicine, UMC, Jackson, MS, 1973-75; gastroenterology fellowship, Ochsner Foundation Hospital, New Orleans, LA, 1975-77; elected by Northeast Mississippi Medical Society.

BUCKALEW, ROLAND E., Houston. Born Salt Lake City, UT, April 21, 1936; M.D., George Washington School of Medicine, Washington, DC, 1968; interned Fairfax Hospital, Falls Church, VA, 1968-69; radiology residency, Riverside Hospital, Newport News, VA, 1969-72; elected by Northeast Mississippi Medical Society.

COLLINS, FRANK B., Hattiesburg. Born Learned, MS, Dec. 5, 1938; M.D., University of Mississippi School of Medicine, Jackson, 1963; interned Naval Hospital, Pensacola, FL, one year; general surgery residency, Naval Hospital, Chelsea, ME, 1965-69; cardiothoracic surgery residency, UMC, Jackson, MS, 1971-73; elected by South Mississippi Medical Society.

COLLINS, ROBERT K., Starkville. Born Farmington, NM, Oct. 27, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned and family medicine residency, same, 1974-77; elected by Prairie Medical Society.

CRAWFORD, JOHN C., Corinth. Born Lake Charles, LA, Feb. 3, 1950; M.D., Louisiana State University School of Medicine, New Orleans, 1976; interned USPHS, New Orleans, 1976-77; elected by Northeast Mississippi Medical Society.

DEBESSONET, DAVID A., Picayune. Born Dec. 13, 1939, Donaldsonville, LA; M.D., Louisiana State

University School of Medicine, New Orleans, 1965; M.D., Wilford Hall USAF Medical Center, San Antonio, TX, one year; urology residency, same, 1967-71; elected by Pearl River Medical Society.

FLOWERS, HARVEY A., Tupelo. Born West Point, MS, May 28, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned Methodist Hospital, Dallas, TX, 1972-73, internal medicine residency, same, 1973-77; elected by Northeast Mississippi Medical Society.

GERSH, H. ALLEN, Hattiesburg. Born Leavenworth, KS, July 11, 1945; M.D., University of Illinois College of Medicine, Chicago, IL, 1970; interned Deaconess Hospital, Buffalo, NY, one year; internal medicine residency, Tripler Army Medical Center, Honolulu, Hawaii, 1972-74; nephrology fellowship, Brooke Army Medical Center, San Antonio, TX, 1974-76; elected by South Mississippi Medical Society.

GILBERT, JOHN B., Meridian. Born Calgary, Alta, Canada, Nov. 15, 1934; M.D., University of Toronto Faculty of Medicine, Toronto, Ontario, Canada, 1961; interned St. Michael's Hospital, Toronto, Can. June 1961-June 1962; internal medicine residency, 1963-64; anesthesiology residency, Sunnybrook Hospital, Toronto, Canada, 1965-67; research fellowship, Sunnybrook Hospital, Toronto, 1961-63; research fellowship, Tufts, Boston, MA, 1967-68; elected by East Mississippi Medical Society.

HECKLER, FREDERICK R., Jackson. Born New York, NY, Mar. 7, 1942; M.D., Tufts University School of Medicine, Boston, MA, 1966; interned University of Chicago Medical Center, Chicago, IL, one year; surgery residency, Tufts Medical Center, Boston, MA, 1967-72; surgery fellow, Malmo, Sweden, 1969-70; Wilford Hall USAF Medical Center, San Antonio, TX, 1973-75, surgery fellowship; elected by Central Medical Society.

HERRIN, THOMAS JONES, JR., Jackson. Born Hattiesburg, MS, May 25, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned Mississippi Baptist Hospital, Jackson, 1969-70; anesthesiology residency, UMC, Jackson, MS, 1970-71; anesthesiology residency, University of Texas Medical Branch, Galveston, TX, 1971-73; elected by Central Medical Society.

HUDGINS, JAMES J., Jackson. Born Houston, TX, Jan. 26, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1968; interned Barnes Hospital Group, St. Louis, MO, one year; surgery residency, UMC, Jackson, MS, 1969-76; vascular surgery residency, same, 1976-77; elected by Central Medical Society.

ISBELL, JIMMY E., Meridian. Born Cedartown, Ga., Oct. 29, 1947; M.D., University of Alabama School of Medicine, Birmingham, 1972; interned Children's Hospital, Birmingham, AL, 1972-73; pediatric residency, same, 1973-75; elected by East Mississippi Medical Society.

MORNEAU, JAMES E., Hattiesburg. Born Dallas, TX, Jan. 25, 1941; M.D., Louisiana State University School of Medicine, New Orleans, 1966; interned LSU Charity Hospital, New Orleans, 1966-67; urology residency, same, 1969-73; fellowship in urology, M. D. Anderson Hospital, Houston, TX, 1973-74; elected by South Mississippi Medical Society.

PARVIN, THOMAS S., Starkville. Born Corinth, MS, Feb. 22, 1942; M.D., University of Mississippi School of Medicine, Jackson, 1967; interned Memorial Hospital, Savannah, GA, one year; general surgery residency, Navy Regional Medical Center, San Diego, CA, 1971-75; elected by Prairie Medical Society.

PRICE, THOMAS H., Starkville. Born New Orleans, LA, May 16, 1945; M.D., University of Pennsylvania School of Medicine, Philadelphia, 1971; interned University of Alabama, Birmingham, one year; pediatric residency, UMC, Jackson, MS, 1974-75; pediatric residency, University of Kansas, Kansas City, 1975-77; elected by Prairie Medical Society.

RHODEN, SANDRA A., McComb. Born Rich Square, NC, Jan. 8, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned and radiology residency, UMC, Jackson, MS, 1973-77; elected by South Central Medical Society.

ROBERTSON, PAUL A., Biloxi. Born Marietta, GA, Nov. 9, 1943; M.D., Tulane University School of Medicine, New Orleans, LA, 1975; interned LSU Medical Center, Shreveport, LA, Jan.-Dec., 1977; elected by Coast Counties Medical Society.

RUBENSTEIN, LOUIS A., Ocean Springs. Born Greenville, MS, April 8, 1941; M.D., University of Mississippi School of Medicine, Jackson, 1967; interned Lloyd Noland Hospital, Birmingham, AL, July 1967-July 1968; elected by Singing River Medical Society.

STEWART, GARLAND SEALE, JR., Columbus. Born Greenwood, MS, Oct. 10, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1971;

interned Baptist Memorial Hospital, Memphis, TN, one year; surgery residency, same, 1972-74; elected by Prairie Medical Society.

THOMAS, DOUGLAS F., Hattiesburg. Born Griffin, GA, Mar. 25, 1943; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned Roanoke Memorial Hospital, Roanoke, VA, one year; internal medicine residency, Naval Aerospace Medical Institute, Pensacola, FL, July-Dec. 1970; internal medicine residency, UMC, Jackson, MS, 1973-76; elected by South Mississippi Medical Society.

VAN DEVENTER, W. H., Meridian. Born Netherlands, Sept. 10, 1930; M.D., State University of Leyden, the Netherlands, 1957; interned Worcester Memorial Hospital, Worcester, MA, Oct. 1958-Oct. 1959; surgery residency, same, 1960-61; anesthesiology residency, Portland, ME, 1961-63; elected by East Mississippi Medical Society.

WELLS, THOMAS G., Pascagoula. Born Waynesboro, MS, Sept. 3, 1942; M.D., University of Alabama School of Medicine, Birmingham, 1969; interned Birmingham Baptist Hospital, Birmingham, one year; orthopedic surgery residency, University Hospital & Hillman Clinics, Birmingham, 1970-74; elected by Singing River Medical Society.

WILSON, ROY D., Jackson. Born Shawnee, OK, June 6, 1931; M.D., Baylor College of Medicine, Houston, TX, 1955; interned Hermann Hospital, Houston, TX, 1955-56; anesthesiology residency, United States AF Hospital, Lackland, TX, 1958-61; elected by Central Medical Society.

YOUNG, WALTER RUSSELL, Brookhaven. Born Bogalusa, LA, Jan. 27, 1946; M.D., Louisiana State University School of Medicine, New Orleans; interned Lake Charles, LA, one year; elected by South Central Medical Society.

DEATHS

SMITH, GERALD A., Sumner. Born Memphis, TN, Jan. 29, 1935; M.D., University of Mississippi School of Medicine, Jackson, MS, 1963; interned Mississippi Baptist Hospital, Jackson, 1963-64; died Mar. 3, 1978, age 43.

WERKHEISER, FRANK E., Jackson. Born Arcadia, LA, May 7, 1897; M.D., Tulane University School of Medicine, New Orleans, LA, 1924; interned Shreveport Charity Hospital, Shreveport, LA, one year; member of the International College of Surgeons; died Mar. 2, 1978, age 81.

PERSONALS

ROBERT F. CASTLE has associated with the Jackson Heart Clinic, P.A. for the practice of pediatric cardiology at Suite 515, 971 Lakeland Drive in Jackson.

CARL EVERS of Jackson and UMC spoke at a meeting of the Mississippi Association of Medical Assistants in Greenwood.

S. R. EVANS, JR., and EDWIN MCLEOD MEEK, JR., announce the formation of The Women's Clinic of Greenwood for the practice of obstetrics and gynecology at 204 Eighth Street.

CHARLES FLOYD of Gulfport made a short-term mission to Honduras sponsored by the Medical Group Missions program of the Christian Medical Society of Oak Park, IL. Dr. Floyd was among a group of 140 medical personnel who conducted a two-week general medical, surgical and dental program there.

EDWARD M. LOWICKI of Jackson announces the relocation of his office for the practice of general, thoracic and cardiovascular surgery to Suite 462, Hinds Professional Building at 1815 Hospital Drive.

NORMAN C. NELSON and JAMES D. HARDY of Jackson and UMC attended meetings of the American Surgical Association in Dallas. Dr. Hardy presented a paper and attended editorial board meetings.

S. RAY PATE of Jackson has been named chief of staff of Riverside Hospital; WILLIAM C. MCQUINN is president-elect; and RICHARD RHODEN is secretary.

J. TATE THIGPEN of Jackson and UMC has been chosen Mississippi's Outstanding Young Man of the Year. He was sponsored by the Jackson Altrusa Club.

FRANK WADE of Magee and his wife, Betty, a registered nurse, have been recognized as outstanding citizens by the Magee Chamber of Commerce. They were honored for teaching young emergency medical technicians to qualify as EMT's and respond to emergency calls in the area.

JAMES WARRINGTON and RICHARD WALLER of Shelby have opened a satellite clinic at Sumner.

Medical Plaza Is Set for Ridgeland Area

Construction has begun on Cates Plaza, a seven-acre development located in Ridgeland, according to Dr. Robert T. Cates, developer of the complex which will include medical-dental facilities, executive and professional office space, and family service and shopping facilities.

According to Dr. Cates, the new facility will help to meet presently unmet needs of this growing area, the N.E. Jackson-South Madison County-Barnett Reservoir area which now has a population of 70,000. Cates Plaza will be located three blocks north of the Jackson city limits on Pear Orchard Road.

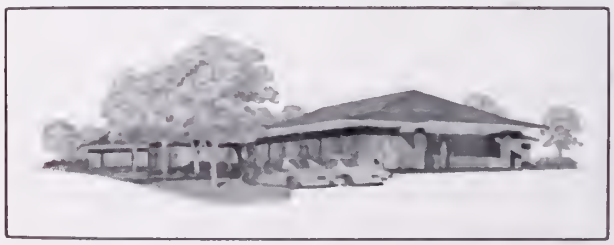
Buildings in the complex will contain approximately 50,000 square feet of space and will be leased to accommodate five general areas of business.

The first phase of the construction, said Dr. Cates, will concentrate on a medical-dental complex, Cates Plaza Clinics, which will include offices for four family physicians, a consulting internist-cardiologist, three pediatricians, two nurse practitioners, four dentists, an ear, nose and throat specialist and a general surgeon.

In addition, said Dr. Cates, plans for Cates Plaza Clinics include space for other health care professionals in the fields of physical therapy, speech therapy, pulmonary therapy and testing, adolescent and child psychology, family counseling, and dietetics.

"We will also be training family practice residents as part of their training at the University Medical Center," said Dr. Cates, who will serve as chief of staff for Cates Plaza Clinics. "Members of our staff would be permanent residents of our community and would therefore be qualified for staff memberships at all the area hospitals and in local, state and national medical associations."

Dr. Cates said that the medical-dental facility will be opened with "x-ray and lab equipment in place" by Aug. 1, 1978. Construction for the entire project is slated to be completed within two years.



This is the artist's rendition of a typical medical-dental office building in the planned Cates Plaza medical-dental complex and specialty shopping center at Ridgeland.

Professional and executive offices are planned for leasing to architects, engineers, interior decorators, realtors and builders, insurance businesses, national and regional sales firms, and state and federal governmental agencies, he said.

Also included will be offices leasable by a major bank branch and a savings and loan association.

Other space will be filled with day nursery and child care center, food market, restaurants and specialty shops. The shopping center will also be available, according to Dr. Cates, for various community functions, such as arts and crafts fairs and band concerts.

Dr. Cates said the entire plaza project has been designed to be "ecology oriented and energy efficient" and he cited the assistance which the development has received from the city of Ridgeland and the Mississippi Research and Development Center.

For more information, contact Dr. Cates at 120 Chinquipin Cove, Jackson 39211 (phone 856-6933).

Dr. Davis Is Named MFMC Medical Director

Dr. J. T. Davis of Corinth was recently named medical director of the Mississippi Foundation for Medical Care by that organization's Board of Directors.



Dr. Davis

Dr. Davis has practiced medicine in Corinth for 42 years. He is a past president and former chairman of the Board of Trustees of the Mississippi State Medical Association. He was also the first president of the Mississippi Foundation for Medical Care.

In a speech before the annual membership meeting of the MFMC in Jackson on May 1, Dr. Davis noted the accomplishments of the MFMC-PSRO and stated that the program was now in a position "to provide evidence that it is having a positive impact on the health services provided in Mississippi."

Dr. Davis stated that "the merits of the PSRO program will have to be demonstrated through objective means during the coming year." "He concluded that the MFMC would "continue to work to improve its physician sponsored and directed review system."

Dr. Carl G. Evers Is Inaugurated President, Dr. Gerald P. Gable Is Named President-Elect

Dr. Gerald P. Gable of Hattiesburg was named president-elect of the association at the closing meeting of the 110th Annual Session, and Dr. Carl G. Evers of Jackson was inaugurated 1978-79 president, succeeding Dr. James O. Gilmore of Oxford.

The five-day meet was headquartered at the Coliseum Ramada Inn in Jackson and featured meetings of the 13 scientific sections, meetings of more than 15 specialty societies, and medical alumni and social occasions. More than 30 essayists presented a varied program which drew praise of registrants.

The registration total was 869 which included 485 members, 22 physician guests, 9 other guests, 135 Auxiliary members, 175 exhibitors, 29 medical students, interns and residents, and 14 staff.

Handling a heavy business agenda, the House of Delegates acted on 14 reports, 7 of which were from the Board of Trustees, and 13 resolutions. Three reference committees conducted hearings before which members and guests appeared for discussion and debate. The Mississippi Medical Fraternal and Educational Society (MMFES) conducted its first annual meeting and program on Sunday and on Monday afternoon, the Mississippi Foundation for Medical Care held its annual meeting.

The president, Dr. Gilmore, presented his address before the Monday session of the House of Delegates. The 1977-78 president discussed the major issues confronting the medical profession today—namely the cost of health care, access to health care and quality of health care. He urged physicians to constructively participate in decision-making and to work within the federation of organized medicine to bring about needed reforms. Dr. Gilmore asked MSMA delegates to carefully consider the matters before the House, particularly in regard to a continuing education requirement for membership.



Three years of the MSMA presidency are shown, from left, Dr. James O. Gilmore of Oxford, immediate past president; Dr. Carl G. Evers of Jackson, president for 1978-79; and Dr. Gerald P. Gable of Hattiesburg, president-elect.



Dr. John H. Budd of Cleveland, OH, president of the American Medical Association, addressed the Monday session of the House of Delegates.







Upper left, members of the reference committees were briefed on their duties during a breakfast meeting on May 1. Speaker C. D. Taylor of Pass Christian and vice speaker R. Faser Triplett of Jackson conducted the session. Lower left, the Council on Constitution and By-Laws debated the resolution referred to it. Lower right, the Reference Committee on Reports of Officers, Board of Trustees and Councils heard members speak on the many and varied reports and resolutions referred to it. At upper right, speaker C. D. Taylor conducts the business of the House of Delegates. He is assisted by vice speaker R. Faser Triplett, shown at right.





110th Annual Session, April 30-May 4, 1978

HOUSE OF DELEGATES ACTS ON MAJOR ISSUES

The House of Delegates of the Mississippi State Medical Association handled a busy agenda of 14 reports and 13 resolutions at the recent 110th Annual Session of the association in Jackson. The official "Transactions" of the meeting will be published in the August issue of the JOURNAL MSMA.

Among major actions by the House of Delegates were approval of reports and resolutions which:

- Authorized the association to commission an independent public opinion poll on the strengths and weaknesses of health care in Mississippi.

- Directed the association to formulate a health plan for the state to identify resources and needs for health care.

- Enacted a voluntary CME program for the membership.

- Urged MSMA members to keep their fees at present levels for the coming year, provided restraint is exhibited by industry, labor and the federal government.

- Adopted a Mississippi Physician-Attorney Interprofessional Code.

- Established a program to identify and rehabilitate the disabled physician.

- Endorsed legislation mandating comprehensive courses in health education in the public schools.

- Endorsed Blue Cross-Blue Shield of Mississippi.

- Opposed AMA sponsorship of SB 218 and HB 1818 (The Comprehensive Health Insurance Act) and urged the AMA to continue to support efforts to build upon the existing freedom-of-choice private insurance system with cost sharing by the patient when financially appropriate and with federal responsibility for the truly indigent.

- Urged the Mississippi State Board of Health to issue guidelines governing the employment of physician assistants.

- Expressed opposition to proposed changes in the "Principles of Medical Ethics."

- Recommended that a "Warning Label" be placed on alcoholic beverages, stating that alcohol can be habit forming and harmful to one's health.

- Scheduled all future annual meetings of the association on the Gulf Coast.

- Supported legislation to increase newborn care resources.

- Established a Section on Urology as the fourteenth scientific section of the association.

- Opposed third party determination of acceptable services and drugs.

- Presented the 1978 Robins Award for Community Service to Dr. Verner S. Holmes of McComb.

- Presented $14,818.39 to the University of Mississippi School of Medicine representing 1977 AMA-ERF Contributions to the school from Mississippi physicians, alumni and their spouses.

The Reference Committee on Credentials reported seating 116 delegates at the opening session of the House of Delegates on Monday, May 1 and 121 delegates at the closing session on Thursday, May 4.

Serving on reference committees of the House were:

Reference Committee on Credentials

J. Elmer Nix, M.D., Chairman
W. B. Hunt, M.D.
J. Dan Mitchell, M.D.

Reference Committee on Reports of Officers, Board of Trustees and Councils

Jack A. Atkinson, M.D., Chairman
James W. Holmes, M.D.
Frank W. Bowen, M.D.
Walter H. Rose, M.D.
William C. Gates, M.D.

Reference Committee on Constitution and By-Laws

W. Lamar Weems, M.D., Chairman
Mary J. Ward, M.D.
Louis C. Lehmann, M.D.

Reference Committee on Rules and Order of Business

Stanley A. Hill, M.D., Chairman
Charles R. Jenkins, M.D.
Matthew J. Page, M.D.

Nominating Committee

Virginia S. Tolbert, M.D., Chairman (District 1)
Beckett M. Howorth, Jr., M.D. (District 2)
Dennis Ward, M.D., (District 3)
W. Bernard Hunt, M.D., (District 4)
Myron W. Lockey, M.D., (District 5)
Austin P. Boggan, M.D., (District 6)
W. Boyce White, M.D., (District 7)
David R. Steckler, M.D., (District 8)
David L. Clippinger, M.D., (District 9)

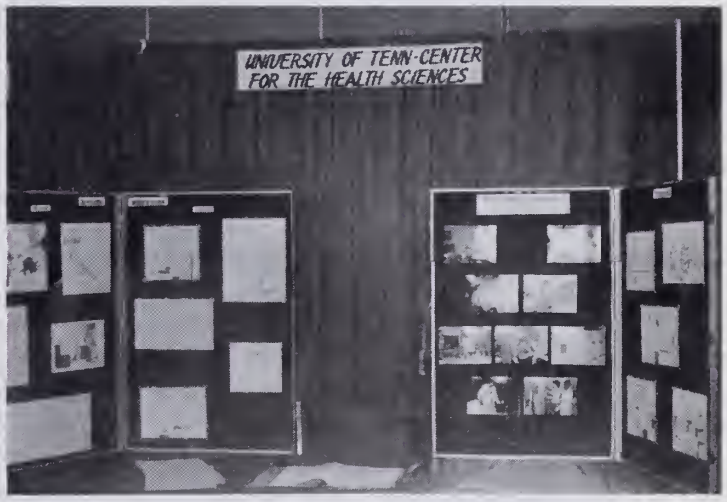
111th Annual Session, May 7-10, 1979, at Biloxi—Mark Your Calendar Now!

Winners of the MSMA scientific exhibit competition for the 110th annual session are shown at right. Upper photo, "Multiple Valve Replacement with the Porcine Xenograft," by Drs. Jeff Hollingsworth, Henry Tyler, William Rosenblatt, James Hays, James Crosthwait, Quinton Dickerson, Thomas Paine, Arthur Jones, and George McMullan, Mississippi Heart Institute-St. Dominic Hospital in Jackson, won the first place Aesculapius award for the best presentation by a member(s) of the association.





"Non-Invasive Cerebrovascular Evaluation," by Drs. Seshadri Raju and James D. Hardy, Department of Surgery, University of Mississippi Medical Center, won the second place Aesculapius award.



Winning the best exhibit by a nonmember citation was "Pain Clinic and Its Relations to General Medicine," by Drs. Joseph S. Hudson, Kit S. Mays, William C. North, William L. Webb, and James T. Robertson, University of Tennessee-Center for the Health Sciences, Memphis.

The House of Delegates commended Dr. Gilmore for his outstanding work as 1977-78 president of MSMA and belatedly presented the 1976-77 president's certificate to Dr. Lyne S. Gamble of Greenville who was absent, due to illness, from the 1977 annual session.

Also in the rostrum spotlight was Dr. John H. Budd of Cleveland, OH, president of the American Medical Association, who discussed the activities of the AMA particularly the legislative proposals before Congress and national health insurance plans.

A gift of $14,818.39 was made to the University Medical Center by the state medical association. medical alumni and MSMA Auxiliary AMA-ERF campaigns.

Vice presidents named to serve during 1978-79 are Drs. William L. Kahlstorf of Tupelo for the northern area, J. George Smith of Jackson for the midstate area, and Thomas R. Singley of Pascagoula for the southern area.

Dr. R. Faser Triplett of Jackson was elected speaker of the House of Delegates and Dr. Walter H. Rose of Indianola is the new vice speaker.

Dr. W. Moncure Dabney of Crystal Springs was named to another two-year term as editor of the JOURNAL MSMA and Dr. George H. Martin of Vicksburg was re-elected associate editor.

Dr. W. Lamar Weems of Jackson was elected as delegate to the AMA and Dr. James V. Ferguson was named alternate delegate.

Delegates, tallied at 121 in the May 4 balloting, elected Dr. J. O. Manning of Jackson as trustee for District 5 and Dr. W. Boyce White of Laurel for District 7. Re-elected to the Board were Drs. Sidney O. Graves of Natchez (District 8) and Paul H. Moore of Pascagoula (District 9).



Members of the Fifty Year Club participated in their annual luncheon meeting during the annual session. Club "officers" are Board Chairman, Dr. Robert S. Caldwell of Tupelo, and MSMA Membership Director Barbara Shelton, who serves as secretary.



Past presidents of the association enjoy a fraternal and traditional breakfast. Immediate past president, Dr. Lyne S. Gamble of Greenville, was host.



Shown above are officers of MSMA and the component medical societies who enjoyed their third annual breakfast meeting to discuss the relationship of the association to the component societies.

Elected to the Council on Budget and Finance for three-year terms were Drs. Sam B. Johnson of Jackson and C. D. Taylor, Jr., of Pass Christian. To serve another term on the Council on Constitution and By-Laws is Dr. Louis C. Lehmann of Natchez.

Drs. William B. Hunt of Grenada, James P. Spell of Jackson and William M. Gillespie of Meridian were elected to the Judicial Council.

Elected to serve three-year terms on the Council on Legislation were Drs. Charles R. Jenkins of Laurel, Walter W. Crawford of Tylertown and Dewey H. Lane, Jr., of Pascagoula.

Drs. Whitman B. Johnson, Jr., of Clarksdale, William H. Booth, Jr., of Holly Springs, and Lee H. Rogers of Tupelo were elected to the Council on Medical Education.

Elected to the Council on Medical Service were Drs. Donald R. Ellis of Clarksdale, David A. Ball of Batesville, and Thomas N. Braddock of West Point.

The five-day annual meeting was approved for 15 hours of credit toward continuing education requirements of the American Academy of Family Physicians and the AMA's Physician Recognition Award.

Mrs. G. Sam Rowlett of Vicksburg was inaugurated president of the Auxiliary in their concurrent annual meeting. Outgoing president was Mrs. William M. Hilbun, Jr., of Tupelo.

Among the social occasions of the week were medical alumni meetings of Ole Miss, Tulane and Tennessee medical schools, the Ole Miss Guardian Society banquet, the MSMA President's reception, the Fifty Year Club luncheon, past presidents' breakfast, the annual breakfast meeting of the officers of MSMA and the component societies, and the MSMA fellowship party.

The second annual MSMA tennis tournament was conducted on Wednesday, May 3, at River Hills Club in Jackson. Dr. Henry B. Tyler of Jackson again chaired this event in which men and women competed. The winners were (two 1st place winners) Drs. Ray Kimble of Greenville and William Gates of Columbus; and women's division—1st place, Mrs. Roger Arhelger of Jackson and 2nd place, Mrs. S. Ray Pate of Jackson.

Board of Trustees Names 1978-79 Officers

Two new names appear on the roster of the association's governing body, the Board of Trustees. Elected by the House of Delegates were Drs. J. O. Manning of Jackson, representing District 5, and W. Boyce White of Laurel, District 7. Dr. Manning replaces Dr. Max L. Pharr of Jackson, who declined to run for re-election; and Dr. White replaces Dr. Gerald P. Gable of Hattiesburg who retired from the Board after serving the maximum number of terms.

Dr. Sidney O. Graves of Natchez was re-elected trustee of District 8 and Dr. Paul H. Moore of Pascagoula was named to another term representing District 9.

Dr. Robert S. Caldwell of Tupelo, District 3, was re-elected chairman of the Board; Dr. Arthur A. Derrick of Durant, District 4, was named to another year's service as vice chairman; and the Board's new secretary is Dr. Paul H. Moore. The chairman, vice chairman and secretary make up the Executive Committee.

Continuing to serve on the Board are Drs. Whitman B. Johnson of Clarksdale, District 1; John R. Lovelace of Batesville, District 2; Ellis M. Moffitt of Jackson, District 5; Joe S. Covington of Meridian, District 6; Carl G. Evers of Jackson, president; and James O. Gilmore of Oxford, immediate past president.

Six general officers meet with the Board: president-elect, secretary-treasurer, speaker of the House of Delegates, vice speaker, and the two AMA delegates.

Scientific Assembly Begins Work for '79

The 1979 annual session is set for May 7-10 in Biloxi. The Council on Scientific Assembly has already begun planning for the 111th.

Acting by separate sections during the recent 110th annual session, the 13 components of the Scientific Assembly named new chairmen and three sections elected new secretaries. In addition, one new section, urology, was approved by the House of Delegates.

Under the By-Laws, a section chairman serves a term of only one year, but section secretaries are elected for three years to provide continuity. Secretaries of the sections are elected on staggered terms.

Each office carries an automatic seat and vote in the House of Delegates to assure proper representation of each scientific specialty.

Named to head the Section on Anesthesiology is Dr. Dexter C. Nettles of Jackson. Section secretary David I. Carlson of Jackson enters the second year of his term.

Dr. James N. McQueen of Jackson will chair the Section on Dermatology. Dr. Thomas C. Garrott of Biloxi enters the final year of his three-year term as section secretary.

Dr. Kenneth N. Reed of Jackson will chair the Section on EENT and section secretary Dr. W. Joseph Burnett of Oxford enters the third year of his term.

Heading the Section on Family Practice is Dr. William H. Spragins of Hollandale and section secretary Gene E. Crick of Minter City enters the second year of his term.



Dr. Carl G. Evers, second from right, is administered the official oath of office by Board Chairman Robert S. Caldwell, at left, and outgoing president James O. Gilmore of Oxford, right. MSMA Executive Secretary Charles L. Mathews holds the historic association Bible.



Dr. Carl G. Evers of Jackson, 1978-79 president of the association, makes his inaugural remarks to the House of Delegates.



Dr. Gerald P. Gable of Hattiesburg, new president-elect of the association, addresses the House of Delegates following his election.



Dr. Verner S. Holmes of McComb, shown at center, is the 1978 recipient of the MSMA-Robins Award for outstanding community service. Presenting the award were Dr. Gilmore, at left, MSMA president, and Mr. Willard Duvall, A. H. Robins Company representative.



Dr. Lyne S. Gamble, right, 1976-77 president of the association, was absent from last year's annual session due to illness. He was belatedly presented the past president's certificate during the 110th annual session by Dr. Gilmore during the Thursday session of the House of Delegates.

The internists chose Dr. W. Mack Gordon of Belzoni as chairman of the Section on Medicine. Entering his final year as secretary is Dr. Don Q. Mitchell of Jackson.

Dr. Kenneth P. Pittman of Jackson heads the Section on Obstetrics and Gynecology. Dr. William L. Kahlstorf of Tupelo is the new section secretary.

Dr. R. Houston Franks of Tupelo is chairman of the Section on Orthopedic Surgery and secretary George W. Wharton of Jackson enters his second year.

Pathologists chose Dr. Allen M. Read of Natchez as chairman of the Section on Pathology. Dr. William B. Wilson of Jackson enters the third year of his term as section secretary.

Dr. R. Ray Lyle of Starkville will serve as chairman of the Section on Pediatrics. Section secretary Robert H. Thompson of Jackson enters the final year of his three-year term.

Dr. Frank J. Morgan of Jackson will chair the Section on Preventive Medicine. The new section secretary, elected for a three-year term, is Dr. Thomas E. Waller of Starkville.

Chairing the Section on Psychiatry will be Dr. G. Howard Freeman of Meridian and secretary Glen Anderson of Brandon will enter the final year of his term.

Heading the Section on Radiology is Dr. Rebecca Harrell of Jackson. New section secretary is Dr. Sandra Rhoden of Jackson.

New chairman for the Section on Surgery is Dr. Charles E. Guice of Hattiesburg. Dr. Jerry R. Adkins of Biloxi continues as secretary of the section.

Dr. Toxey M. Morris of Hattiesburg is chairman of the newly-formed Section on Urology and the secretary is Dr. Ronald L. Brown of Gulfport.

Dr. J. Elmer Nix of Jackson, association secretary-treasurer, is constitutional chairman of the Council on Scientific Assembly. He said that the council will be meeting this summer to review preliminary plans for the 111th annual session and to begin actively working on the program.

The exhibit prospectus for technical exhibitors will be released this fall. Specialty societies are invited to submit plans for concurrent meetings and requests for assignments of rooms, including those for meal occasions, he added.

The president, Dr. Carl G. Evers of Jackson, and the president-elect, Dr. Gerald P. Gable of Hattiesburg, are *ex officio* members of the council.

Specialty Societies Hold Concurrent Meetings

More than 15 specialty societies and related groups met concurrently with the association during the 110th annual session at the Coliseum Ramada Inn. Scientific sessions and social occasions drew members of almost every specialty.

The Mississippi Urological Society held a luncheon and scientific session on Saturday, April 29.

Pathologists from throughout the state attended the April 30 luncheon meeting of the Mississippi Association of Pathologists. The MAP also held a

cocktail party on Saturday night, April 29. Officers are president, Dr. Allen M. Read of Natchez; president-elect, Dr. William B. Wilson of Jackson; and secretary, Hines Bostwick of Jackson.

The Mississippi Orthopedic Society conducted a luncheon meeting on April 30 at the Coliseum Ramada. Society officers are president, Dr. J. Stewart Williford of Hattiesburg; president-elect, Dr. Royce H. Franks of Tupelo; vice president, Dr. Ben H. Buchanan of Tupelo; and secretary, Dr. George Wharton of Jackson.

Psychiatrists convened for a luncheon meeting of the Mississippi Psychiatric Association on April 30.

The Mississippi Society of Anesthesiologists met on Sunday, April 30, for a breakfast meeting at the Coliseum Ramada. Dr. Dexter C. Nettles of Jackson is president.

On Monday, May 1, the Mississippi Gastroenterology Society sponsored a special Gastrointestinal Seminar. Officers of the society are president, Dr. Walter T. Boone of Jackson, and secretary, Joel T. Callahan of Meridian.

A luncheon meeting highlighted the annual gathering of the Mississippi Society of Internal Medicine on May 2. Dr. James C. Hays of Jackson is president and Dr. Bruce E. Atkinson of Amory is secretary-treasurer.

The Mississippi chapter of the American College of Surgeons convened on May 2 for an officers' breakfast, luncheon, scientific session and business meeting. New officers are president, Dr. James D. Hardy of Jackson; president-elect, W. Briggs Hopson of Vicksburg; and secretary-treasurer, Benton Hilbun of Tupelo.

The Mississippi Dermatological Society hosted a breakfast and a luncheon on Tuesday, May 2. President is Dr. James N. McQueen of Jackson; president-elect, Dr. John A. Marascalco of Greenville; and secretary, Dr. Thomas C. Garrott of Biloxi.

The American Academy of Facial Plastic and Reconstructive Surgery, Mississippi chapter, hosted a breakfast meeting on Wednesday, May 3. Officers are Drs. George L. Arrington, Jr., of Meridian, president; W. Joseph Burnett of Oxford, vice president; and J. George Smith of Jackson, secretary-treasurer.

The Mississippi Ob-Gyn Society held a luncheon meeting on Wednesday, May 3. Officers are Drs. H. Lamar Gillespie of Hattiesburg, president; Lewis D. Lipscomb of Jackson, president-elect; Thomas R. Singley of Pascagoula, vice president; and Fred H. Ingram of Jackson, secretary. The Ob-Gyn Advisory Committee also met on May 3.



Presenting the check for AMA-ERF contributions to Dr. Norman C. Nelson (second from right), vice chancellor of the University of Mississippi, is Dr. James O. Gilmore, at left. Assisting in the presentation are Mrs. Dempsey T. Amacker of Natchez, Auxiliary AMA-ERF chairman, and Dr. R. Faser Triplett, vice speaker of the House of Delegates and Ole Miss medical alumni president.



Dr. James O. Gilmore, 1977-78 president of the association, addressed the House of Delegates at the opening session on Monday morning. The entire text of his address will be printed in the July issue of the JOURNAL MSMA.



Mrs. William Hilbun of Tupelo, 1977-78 president of the MSMA Auxiliary, made the Auxiliary's annual report to the House of Delegates on Monday. The 1978-79 president, Mrs. G. Sam Rowlett of Vicksburg, was presented to the House on Thursday.



Dr. Carl G. Evers is shown presenting the James Grant Thompson Memorial Past President Pin to outgoing president James O. Gilmore.



Dr. Kenneth N. Reed of Jackson is the new chairman of the MSMA Section on EENT.



Dr. W. Mack Gordon of Belzoni, right, is the new chairman for the Section on Medicine. He'll be assisted by section secretary Don Q. Mitchell of Jackson.



Dr. Frank J. Morgan of Jackson, right, is new chairman of the Section on Preventive Medicine. Section secretary is Dr. Thomas E. Waller of Starkville.



New officers of the Mississippi Orthopedic Society are from left, Drs. George Wharton of Jackson, secretary; R. H. Franks of Tupelo, president-elect; Stewart Williford of Hattiesburg, president; and Ben Buchanan of Tupelo, vice president.



The new officers of the Mississippi Association of Pathologists are from left, Drs. Allen Read of Natchez, president and MSMA section chairman; William B. Wilson of Jackson, president-elect and section secretary; David R. Steckler of Natchez, treasurer; and Hines Bostwick of Jackson, secretary.



The American Academy of Facial Plastic and Reconstructive Surgery, Mississippi chapter, elected new officers. President George L. Arrington, Jr., of Meridian was unavailable for a picture, but shown from left are Drs. J. George Smith of Jackson, secretary-treasurer, and Joseph Burnett of Oxford, vice president.



The Mississippi Ob-Gyn Society's officers are from left, Drs. Thomas R. Singley of Pascagoula, vice president; Kenneth P. Pittman of Jackson, immediate past president; H. Lamar Gillespie of Hattiesburg, president; Lewis D. Lipscomb of Jackson, president-elect; and Fred Ingram of Jackson, secretary.

Family physicians met at a Mississippi Academy of Family Physicians luncheon on May 3. Dr. P. Evans Adams, chairman, department of adult psychiatry, Albert Einstein Medical Center, Philadelphia, was guest speaker. Officers of the academy are Drs. Ralph L. Brock of McComb, president; John M. Estess of Hollandale, president-elect; and J. Edward Hill of Hollandale, secretary.



Past and present officers for the MSMA Section on Ob-Gyn are shown from left, Drs. William L. Kahlstorf of Tupelo, newly-elected secretary; Kenneth P. Pittman of Jackson, new chairman; Richard Hollis of Amory, outgoing chairman; and Wadie Abraham of Meridian, outgoing secretary.

The Mississippi EENT Association held a luncheon and business meeting on May 3. Officers are Drs. George L. Arrington, Jr., of Meridian, president; Fred L. McMillan of Jackson, vice president; and Wilson E. Moak of Jackson, secretary-treasurer.

Council members include Drs. Leighton Pettis of Tupelo, immediate past president; Lee Rogers of Tupelo; Michael Taleff of Meridian; L. Stacy Davidson of Cleveland, representative to the American Association of Ophthalmologists; and Chester Masterson of Vicksburg, representative to the American Council of Otolaryngology. EENT Council also met.

A Short Course in Practical Tonometry for Non-ophthalmologists was again sponsored by the Mississippi Society for the Prevention of Blindness on Wednesday, May 3.

Flying physicians in Mississippi were guests at a Flying Physicians Association, Mississippi chapter, dinner and program on May 3. New officers are Drs. W. E. Riecken of Jackson, president and T. R. Singley of Pascagoula, secretary-treasurer.

The State Perinatal Committee held an organizational breakfast on Wednesday, May 3.

Index to Advertisers

Burroughs Wellcome Co.	8
Canton Exchange Bank	11
Citizens Bank and Trust Co.	14
Dermik Laboratories	second cover
Doctors Needed	11
Harreld Chevrolet-Oldsmobile	15
Hill Crest Hospital	6
Eli Lilly and Co.	18
Premier Printing Co.	113
Riverside Hospital	7
Roche Laboratories	4, 10, 10A, third and fourth covers
Sheraton-Biloxi Motor Inn	16
Smith Kline and French	10B
The Upjohn Co.	12
Warren-Teed	17
Thomas Yates and Co.	3

IN CONCLUSION

If California's Department of Alcoholic Beverage Control has its way, intoxicated persons in Los Angeles and its environs are going to find it increasingly difficult to buy drinks at establishments licensed to sell liquor to the public. The reason is a demonstration program now underway in which ABC staff train employees of such establishments in how to avoid serving drinks to an intoxicated customer. Other methods establishments can use are setting "house limits" for drinking by a patron and training employees to detect intoxicated customers.

The issues involved in formulating a national health care program put "a nearly impossible burden on the physician: to limit the amount and scope of his services," according to the April issue of the Mercer Bulletin. Consumers, the medical profession, the insurance industry and government, the bulletin suggests, should be involved "in the design and administration of a national program which improves health and hopefully strikes an accord between the parties involved so that all are motivated to contain future costs."

Doctors would be allowed to purchase equipment worth more than $150,000 to place in their private offices, if they show it will not be used by patients of any nearby hospital which had been denied permission from the local HSA to purchase similar equipment, according to provisions in HR 11488, the Health Planning and Resources Development amendments, slated for floor vote soon. This bill contains many provisions in HR 10460, subject of an AMA Legislative Alert for its provisions detrimental to medicine. It would also exempt HMOs from certificate of need.

Fixed payments, based on a national fee schedule, are proposed for Medicare, Medicaid physicians reimbursement by Robert A. Derzon, administrator of HEW's Health Care Financing Administration. Claiming disparity in payments made in rural and urban areas, Derzon cited that in rural Texas, the prevailing charge for a routine office visit is $7.70 compared with $15 in Galveston. His remedy, he said, would be fee schedules for both Medicare and Medicaid, consisting of a list of maximum allowed reimbursements for a group of medical procedures.

For most people caffeine is an enjoyable mild stimulant offering little risk of any harmful effects, according to an article in Nutrition Reviews. Recent experiments have not shown that caffeine consumption is a cause of heart disease or other health risks, reports the National Academy of Sciences. A recent survey by an academy committee showed 82% of adults surveyed (age 18 and over) consumed caffeine at an average of 186 mg or about two cups of coffee per day. The stimulant prevents attention lapses and improves the performance of physical tasks.

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For recurrent attacks of urinary tract infection in women

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Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.



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Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension*, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Please see reverse side for summary of product information.

July 1978

BALCONY

Journal of the State Medical Association

Mississippi



Contents:

Factors Affecting Physician Participation in the Mississippi Medicaid Program

Address of the President

Evaluation of Renal Mass Lesions

Front Runner



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Contraindications: Topical steroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

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If extensive areas are treated or if the occlusive technique is used, there will be increased systemic absorption of the corticosteroid and suitable precautions should be taken particularly in children and infants.

Although topical steroids have not been reported to have an adverse effect on human pregnancy, the safety of their use in pregnant women has not absolutely been established. In laboratory animals, increases in incidence of fetal abnormalities have been associated with exposure of gestating females to topical corticosteroids, in some cases at rather low dosage levels. Therefore, drugs of this class should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

The product is not for ophthalmic use.

Adverse Reactions: The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliaria.

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Basic Decision Is Needed on NHI

The direction the Carter administration's national health insurance proposal will take apparently rests on a basic decision by the President himself—namely whether to go for a targeted or broad approach to NHI.

The targeted approach will probably consist of providing basic health benefits to all those below the poverty level by strengthening and expanding the current Medicaid program with some type of catastrophic coverage for the rest of the population such as that proposed by Senators Long, Talmadge, Ribicoff and others. It is estimated that the targeted approach will cost some $15-27 billion dollars in new federal funds.

The broad approach will probably consist of providing basic health benefits to everyone in the country via some federal and/or federal-private insurance mechanism. The broad approach will cost some $40 billion in new funds.

Hospital Services and LOS Influence Care

Hospitals with the lowest death rates are those that maximize patient services and minimize length of patient stay, according to a Stanford University Medical Center study.

The study of discharge information on 600,000 patients from 1970 to 1973 revealed that greater than average service was most often associated with large hospitals, more facilities, high occupancy rates and coordination of work at the ward level. Coordination of patient care activities was also associated with shorter length of hospital stay.

According to Dr. William H. Forrest, Jr., director of the Stanford Center for Health Care Research, those hospitals providing the least services and longer-than-average patient stays had the highest death rates.

Ironically, below average patient services in such areas as diagnostic and clinical examinations were most often experienced in hospitals whose surgeons had longer years of experience. Greater than expected length of stay was most often correlated with high administrative influence and high hospital cost per patient.

"These results have the appeal that goes with the belief that intensive service should yield better care," the researchers conclude in their report.

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CONTENTS

ORIGINAL PAPER

Factors Affecting Physician Participation in the Mississippi Medicaid Program — 129 — Dewey D. Garner, Winston C. Liao, and Thomas R. Sharpe, University, MS

SPECIAL ARTICLES

Address of the President — 132 — James O. Gilmore, M.D., Oxford, MS

Radiologic Seminar CLXXXIII: Evaluation of Renal Mass Lesions — 134 — Philip E. Cranston, M.D., Jackson, MS

EDITORIAL

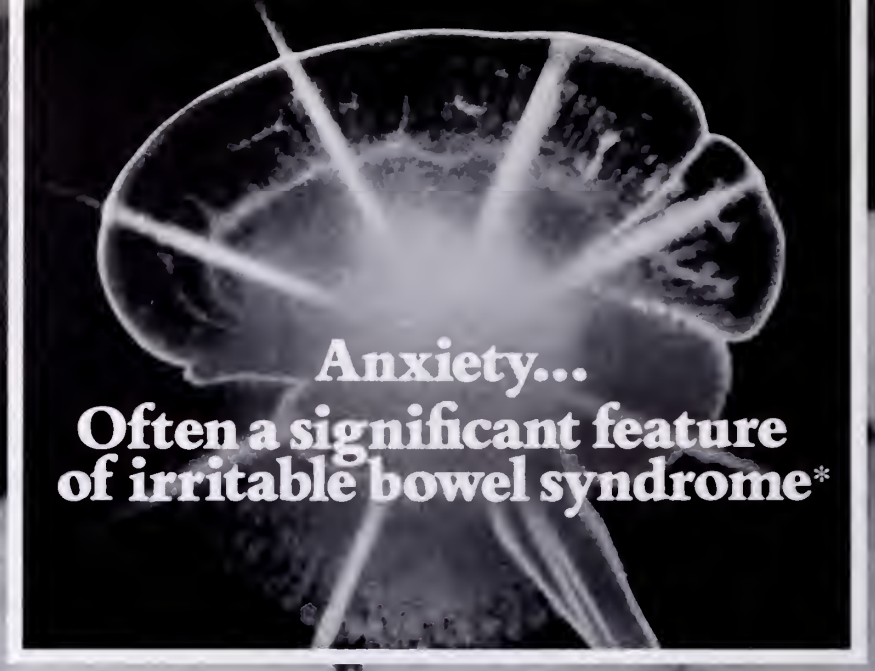
The Federal Trade Commission — 139 — Myron W. Lockey, M.D., Jackson, MS

THIS MONTH

The President Speaking — 138

Medical Organization — 143 — Medicaid Fee Increases Are Implemented in Mississippi

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Final classification of the less-than-effective indications requires further investigation.

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Confidentiality of Medical Records Stressed

Patients' right to confidentiality of health care information needs better protection in today's record- and computer-oriented health care systems, the American Medical Record Association (AMRA) has asserted in a major policy statement.

In releasing the document, entitled "Confidentiality of Patient Information, A Position Statement of the American Medical Record Association," Mrs. Mary J. Waterstraat, executive director of the association, urged that patients be given access to their records except when barred by specific legal or physician-recommended constraints. She also called for much stricter authorization requirements for health record data release.

Mrs. Waterstraat stressed the need to limit routine collection of data to that needed for specific treatment and to insure that patients are fully informed of what information is being requested, by whom and for what purpose before consenting to its release.

AMRA also voiced a concern that patients, uncertain whether sensitive information would be held in confidence, might withhold critical facts which could affect the quality of health care provided.

HMOs Receive Opposition From Congress

The Administration's $500 million Health Maintenance Organization (HMO) bill ran into opposition from key Senators alarmed over reports of widespread fraud and abuse.

"Wouldn't it be best to put brakes on the whole HMO program?" asked Sen. Herman Talmadge (D-Ga.), chairman of the Senate Finance Subcommittee on Health. Sen. Sam Nunn (D-Ga.), vice chairman of the Senate Permanent Subcommittee on Investigations, agreed. Sen. Carl Curtis (R-Nebr.) said that if HMOs are "any good, they will grow on their own" without the need for any federal subsidy.

Nunn told the Finance Subcommittee that "unless remedial action is taken, the federal government, through its program of financing the development of HMOs, faces the prospect of encountering nationwide the same kinds of scandal and abuse that have plagued the California Medicaid program." There is evidence that organized crime is moving into the HMO field, the Georgia senator warned.

The Investigations Subcommittee recently released a report charging large scale abuse and fraud in the California HMO program.

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NEWSLETTER

July 1978

Dear Doctor:

The Kidney Foundation of Mississippi has announced the establishment of a new program--The Kidney Foundation of Mississippi Drug Bank Program. The purpose of the program is to assist those patients with kidney disease and/or chronic urinary tract conditions in reducing the financial burden of the cost of drugs. The procedure for determining eligibility for the drug bank program is explained below. For further information, call the kidney foundation at 981-3611.

> The attending physician must certify that the patient has a kidney disease or chronic urinary tract condition that will extend for at least 90 days. Certification is mailed to the kidney foundation at P. O. Box 4883, Jackson 39216. The patient is issued an identification card to receive a discount on drugs at participating pharmacies.

In evaluating current directions of the Joint Com. on Accreditation of Hospitals, president J.E. Affeldt said survival of this standards-setting mechanism hinges on the capability of voluntary efforts by health care providers to self-police quality of health care. "The Joint Commission cannot stand alone. It requires all the health providers to recognize and agree that they want a voluntary effort," he said.

There is a group of unvaccinated persons in the U.S. that is still at risk of contracting poliomyelitis, says a report in a recent JAMA. The article's findings recommend that boosters should be given to children just before school entry, and offered to persons who plan to travel in areas where the disease is still prevalent. There were only seven new cases of polio in 1975 in the U.S.

A recent study involving men and women medical students at the University of Kansas Medical Center showed there were no significant differences in final course grades between the two sexes. Performance in wards and clinics and on written and oral examinations was also without significance. Gender would appear to have no relationship to medical student performance in this clinical clerkship.

A recently passed Virginia statute removes the general statutory prohibition against physician advertising, and instead prohibits only that advertising which "(i) is false, deceptive or misleading, (ii) contains a claim of superiority, or (iii) violates such regulations as may be promulgated by the Board governing advertising..." (Chapter 622, Laws 1978). This item was reported in the AMA Legislative Roundup.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

Fewer MDs and Equal Pay Recommended

Primary care doctors should be paid as much as specialists for performing the same services, a study by the Institute of Medicine concludes. The recently issued report says specialists should be paid more only when the patient has been referred to them by the primary care doctor.

The report, "A Manpower Policy for Primary Health Care," also urges putting a lid on the number of medical and osteopathic students for the next 10 years. This proposed moratorium also would halt plans for new medical schools—some of which are already underway.

The reason, the 14-member study committee says, is that there are now so many medical students that by 1990 the number of doctors in this country will have increased 60 per cent. Every new doctor adds $250,000 a year to the nation's health care bill, according to the committee.

And, because there will be so many more doctors, the study says HEW should not increase the training rate of nurse practitioners and physicians assistants. More than 40,000 will have been trained by 1990 without increasing the rate, the report says.

Not only should primary care doctors get the same pay as specialists for the same work, the report also recommends that third party payers eliminate "all geographic differentials in payment levels for physician services within a state." This would equalize reimbursement between doctors practicing in rural or poor urban areas and those in the higher income areas.

In another controversial area, the committee recommends that third-party payers should reimburse hospitals and clinics the same amount for the same services no matter who performs the service, nurse practitioner, physician assistants or doctors.

HEW Will Stress Second Opinions

HEW is preparing to launch a program to encourage second opinions for surgery for Medicare/Medicaid patients. Patient pamphlets, physician enrollment, and radio-television ads ("second opinion —it's good for you") are projected.

"List-developers" will set up lists of physicians willing to participate in a second opinion (SO) program, on patient request. "List holders" will operate telephone referral centers to which patients may apply for the names of participating physicians.

The Health Care Financing Administration of the HEW Department believes professional standards review organizations (PSROs) are the logical units to handle the "list" functions and has approached the Mississippi Foundation for Medical Care—PSRO in this regard. However, carriers and medical societies also are eligible.

Public campaigns will begin soon and will consist of brief TV spot announcements and longer radio "dramas" on "SO" which will be distributed to stations. Five million leaflets will be distributed with Social Security checks in selected areas.

For Medicare patients, the program will pay for the second opinion as for other consultations, at 80 per cent of the "reasonable charge," while Medicaid participation and payment, thus far, is at the option of the individual state. This may pose a problem in some states.

As presently planned, use of the "second opinion" will be at the patient's option, and the second opinion will not control payment for services.

The "SO" program is based on the assumption that second opinions will forestall unnecessary surgery.

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* **INDICATIONS:** Based on a review of this preparation by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: **Possibly effective:** In cutaneous candidiasis; superficial bacterial infections; the following conditions when complicated by candidal and/or bacterial infection: atopic, eczematoid, stasis, nummular, contact, or seborrheic dermatitis, neurodermatitis, and dermatitis venenata; infantile eczema; lichen simplex chronicus; and pruritus ani and pruritus vulvae.

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Viral diseases of the skin (such as vaccinia and varicella); fungal lesions of the skin except candidiasis, history of hypersensitivity to any product component. Not intended for ophthalmic use; should not be applied in the external auditory canal of patients with perforated eardrums; should not be used when circulation is markedly impaired.

WARNINGS: Because of the potential hazard of nephrotoxicity and ototoxicity, prolonged use or use of large amounts of this product should be avoided in the treatment of skin infections following extensive burns, trophic ulceration, and other conditions where absorption of neomycin is possible.

Usage in Pregnancy: Although topical steroids have not been reported to have an adverse effect on the fetus, the safety of topical steroids during pregnancy has not been absolutely established, therefore, do not use extensively on pregnant patients, in large amounts, or for prolonged periods.

PRECAUTIONS: Watch constantly for overgrowth of nonsusceptible organisms (including fungi other than candida). Should superinfection due to nonsusceptible organisms occur, administer suitable concomitant antimicrobial therapy. If favorable response is not prompt, discontinue the preparation until adequate control by other antiinfectives is effected. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid; suitable precautions should be taken. If irritation develops, discontinue the product and institute appropriate therapy.

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For full prescribing information, consult package insert.

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HEW Opposes Voluntary Cost Controls

The Health, Education and Welfare Department has asked the Justice Department to delay granting the nation's hospitals an exemption under the anti-trust laws in order to carry out their voluntary cost containment effort.

John Alexander McMahon, AHA president, said that "it seems passing strange that HEW would undermine and even try to undercut our voluntary effort" by taking this position before Justice.

HEW told Justice in a letter there may be "a serious lack of public accountability and public participation in the Voluntary Effort conducted by the AHA, the American Medical Association and the Federation of American Hospitals.

HEW General Counsel wrote Justice that the Voluntary Effort might discriminate against smaller community hospitals and health maintenance organizations and also might work to hold down wages of hospital workers.

HEW has been hostile to the Voluntary Effort from the outset, contending that only mandatory federal controls as embodied in the Administration hospital cost containment program are the answer to inflation in hospital costs.

AMA Is Critical of Drug Reform Bill

The sweeping drug bill before Congress signals a shift in philosophy "where government takes it upon itself to 'protect' patients from their physicians," the AMA has told the Senate Human Resources Subcommittee on Health.

The current philosophy is that of a "joint effort of government and the medical profession to protect unsuspecting patients from unethical manufacturers and vendors," testified Lowell H. Steen, M.D., a member of the AMA Board of Trustees.

The subcommittee, headed by Sen. Edward Kennedy recently held four days of hearings in a debate-type format on various provisions of the Administration's ambitious proposal to revamp the drug laws.

Dr. Steen said the provisions aimed at "protecting" patients "would unjustifiably interfere with the practice of medicine by placing the FDA between the physician and the patient through the imposition of national standards and criteria for use of drugs."

The bill gives the FDA power in determining safety of a drug, such factors as abuse potential, whether the drug is being used for non-approved uses, whether FDA believes there is a more appropriate drug or treatment, and whether the drug would have an adverse effect upon public health, the AMA witness noted.

Miss. Baptist Medical Center Plans Cardiovascular Symposium

The Mississippi Baptist Medical Center has set its annual cardiovascular symposium for Sept. 22-23 at the Downtown Holiday Inn in Jackson.

Featured speakers will be Dr. Frederick Cobb, associate professor of medicine, Duke University Medical Center; and Dr. Albert Oberman, director, division of private medicine, and professor, department of public health, University of Alabama, Birmingham.

For further information contact Dr. Martin McMullan, 1600 North State Street, Jackson, MS 39202.

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DATELINE

Saccharin Study Is Set for Five States

Washington, DC - Persons in five states and four metropolitan areas will take part in a program to find out the role of saccharin in causing bladder cancer in humans. It is being funded mainly by the National Cancer Institute and the U.S. Food and Drug Administration. The large, population-based study will be conducted to determine whether the proven association between saccharin and bladder cancer in animals also applies to humans. Nine thousand persons will take part in the study.

Injuries Occur From Exploding Pop Bottles

Phoenix, AZ - A report on injuries from exploding soft drink bottles in JAMA last fall prompted responses from other physicians who had treated such injuries. Paul S. Bergeson, M.D., and colleagues from Good Samaritan Hospital report they have been able to expand their account from 3 to 17 cases. Hot weather may be a factor and of course, the few explosions offer slight risk when related to the many millions of bottles handled daily. Voluntary standards for bottle strength have also been set.

Residents Have Significant Problems

Kansas City, MO - The psychologically impaired resident--one disabled by drug abuse, alcoholism or emotional illness--has been the subject of a recent study by the AAFP Committee on Mental Health of 325 family practice residency programs. Problems most commonly encountered were emotional illness, marital problems, economic problems, drug abuse and alcoholism--in that order. Many of the residencies did have identifying and rehabilitation programs but few stressed preventing resident impairment.

Behavioral Therapy Helps the Obese

Philadelphia, PA - Behavioral therapy offers new promise in helping obese children to get rid of the excess pounds, says a report in American Journal of Diseases of Children. Obesity is one of the most refractory health problems facing the physician today, say Drs. K.D. Brownell and A.J. Stunkard of the University of Pennsylvania Medical School. At least 25 per cent of all children are obese and will likely grow up to be obese adults with consequent health problems, they say.

Jailers Will Screen Inmates for Disease

Chicago, IL - For the first time in the history of American jails, a national program has been developed to train jailers on how to screen inmates for illness and provide emergency first-aid. "We don't think disease should be an add-on sentence for people who may only be waiting for trial," said Joseph Rowan, director of the AMA Jail Project. Testing of manuals for students and instructors, visual aids and a slide show will take place in Illinois and Indiana.

Medical Center Adds to Faculty

A professor, two assistant professors and an instructor have joined the School of Medicine faculty at the University of Mississippi Medical Center.

Dr. Norman C. Nelson, UMC vice chancellor for health affairs, announced the appointments following approval of the Board of Trustees, State Institutions of Higher Learning.

The new faculty members are Dr. Garfield Tourney, professor of psychiatry and human behavior; Dr. Bevan E. Steadman, assistant professor of psychiatry; Dr. George William Bates, assistant professor of obstetrics and gynecology; and Dr. TaeHae Kwon, instructor in obstetrics and gynecology.

Dr. Tourney, professor of psychiatry and chairman of the department at Wayne State University School of Medicine since 1973, assumed his UMC duties in July. He also had served as head of psychiatry at Detroit's Harper Hospital since 1971.

Dr. Tourney earned the B.S. degree at the University of Illinois in 1946 and the M.D. at the Illinois College of Medicine in 1948. He interned at University Hospitals in Iowa City and took residency training at the State University of Iowa Psychopathic Hospital. He earned the M.S. degree at the State University of Iowa in 1952.

Staff psychiatrist at the Psychopathic Hospital in Iowa City from 1967-1971, Dr. Tourney was formerly assistant director in charge of education at Lafayette Clinic in Detroit. He is the author of more than 55 scientific articles, including major publications on schizophrenia and the history of psychiatry. He is a fellow of the American Psychiatric Association and the American College of Physicians and has been an associate examiner for the American Board of Psychiatry and Neurology since 1967.

Dr. Steadman, a B.A. graduate of the University of Houston, earned the M.D. at the University of Texas Medical Branch in Galveston in 1971. He interned at Maricopa County General Hospital in Phoenix, AZ and took residency training at the State Mental Health Institute in Cherokee, IA. Since 1976, Dr. Steadman has served in the U.S. Air Force. He joined the UMC faculty in June.

Dr. Bates, who assumes his new duties this month, comes to UMC from Dallas where he has held a fellowship at the University of Texas Southwestern Medical School since 1976. He earned the B.S. degree at the University of North Carolina in 1962, and the M.D. at the University's School of Medicine in 1965. He interned at the University of Alabama Medical Center in Birmingham and took residency training at the North Carolina Medical Center in Chapel Hill. Dr. Bates was professor of obstetrics and gynecology and chairman of the department at the University of Tennessee Clinical Education Center in Knoxville from 1975-1976.

A UMC fellow since 1976, Dr. Kwon joined the School of Medicine faculty June 1. After earning the M.D. degree at Seoul National University College of Medicine in Korea in 1965, Dr. Kwon interned at Elmhurst General Hospital in Elmhurst, NY. He was a resident and fellow at Lenox Hill Hospital in New York City from 1970-1976.

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UMC Medical Students Are Inducted into AOA

Twenty-five medical students were named to membership in Alpha Omega Alpha at the University of Mississippi Medical Center this spring.

They included Harrell Edward Cox, Robert Moore Evans, Jefferson Allen Fletcher, Bruce Woodall Lambuth, Benjamin Allen Root, Jr., Thomas Allen Thompson and Jill McLaurin Woodliff, all of Jackson; Jack Byrd Foster, Jr., Charles Edwin Guice, III, Joseph Randall Moorman and John Kenneth Wallace,

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1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

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The AMA Computer Systems in Medicine Consultative Services Program

The American Medical Association recognizes the potential that computers have in the health care setting. Therefore, the AMA has initiated the **Computer Systems in Medicine Consultative Services Program.** Through this program, physicians who are considering computer services as well as current users who want to improve or expand their computer applications can obtain an objective viewpoint and expertise in methods and equipment.

Computers have the potential to be a tremendous asset to the medical community, and have possible application in some or all of the following:

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While the major thrust of the **Consultative Services Program** will result from interest in the use of computers or computer-related services, the primary goal of the consultant is to recommend the most advantageous treatment of each situation. **The focus is the needs and objectives of the client,** not the promotion of computerized solutions.

For a more detailed description of this new and valuable service or to arrange a consultative visit, contact: John A. Guerrieri, Jr., Program Director, Consultative Services Program, at (312) 751-6417.

of Hattiesburg; and James Robert Haltom and Van Lancy Lewis, both of Natchez.

Other ΑΩΑ initiates were Cynthia Gale Brumfield of Tylertown, Michael Lee Davis of Indianola, William Timothy Denton of Pope, John Philip Foster of Houston, Richard Douglas Gilliland, Jr., of Ackerman and Marshall Lagrone Horton, III, Walnut. Also, Gerry Ann Goodson Houston of Baldwyn, John David McBrayer of Columbus, Dwain Rafel Rieves of Smithville, Bobby Darrel Smith of Ellisville, William Robert Smith of Wesson, and Alfred Gerwin Windham of Edwards.

Dr. Charles C. Randall, UMC professor of microbiology and department chairman, who retired this month, was the faculty initiate.

Dr. Adolph L. Sahs, professor emeritus of neurology and former chairman of the Department of Neurology at the University of Iowa College of Medicine, was guest speaker for the May 11 ΑΩΑ dinner for initiates and members and Honors Day May 12.

New Champus Intermediary Is Announced

Beginning June 1 Mutual of Omaha Insurance Company became the fiscal intermediary for CHAMPUS claims in Mississippi replacing Blue Cross-Blue Shield of Mississippi in that capacity.

According to CHAMPUS "Mutual of Omaha was selected on the basis of competitive bidding. The organization submitted the best overall proposal for administering payment of CHAMPUS claims. . . ."

Prior to last year MSMA had served as fiscal intermediary for physician services under CHAMPUS in Mississippi. At that time CHAMPUS made a decision to go to regional fiscal intermediaries and Blue Cross-Blue Shield became CHAMPUS fiscal intermediary for both hospital and physician services in Mississippi and Louisiana.

CHAMPUS claims should be sent to Mutual of Omaha, 3301 Dodge Street, Omaha, NE 68131.

New Facility Opened For Alcoholics

The Stevens Center, a residential alcoholism treatment and rehabilitation facility, has opened in Jackson County and becomes the fourth such facility to be established with funds provided by the three per cent tax on alcoholic beverages.

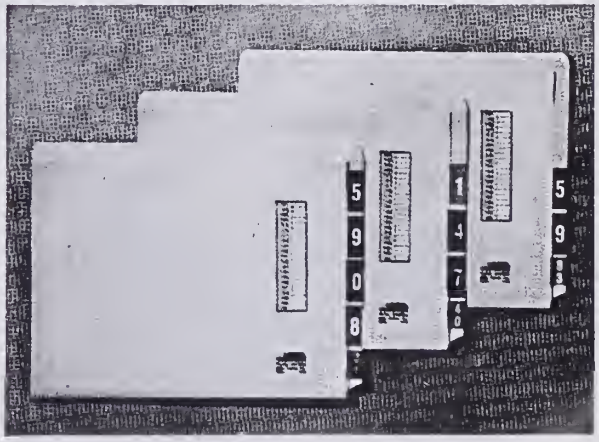
Named for the late Gil Stevens, first director of Singing River Alcoholic Services, the center is located in the nurses quarters of the old Moss Point Hospital at 4421 Jefferson Street in Moss Point. The seven-bed facility, which serves men and women of Jackson and George counties, is under the sponsorship of Singing River Mental Health Services in Pascagoula.

The treatment program at The Stevens Center lasts six weeks and is oriented to the individual and the whole aspect of his disease. Detoxification is provided at Singing River Hospital before a client begins the recovery program which consists of individual, group, occupational and family therapy, lectures, films, and participation in Alcoholics Anonymous.

After the six weeks residential program is completed, a two year aftercare program is designed by the center staff and the client himself.

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State Medical Students Choose Primary Care

Responding to the nation's need for more primary care physicians, Mississippi medical students are choosing residencies in family medicine, internal medicine, obstetrics and gynecology, and pediatrics.

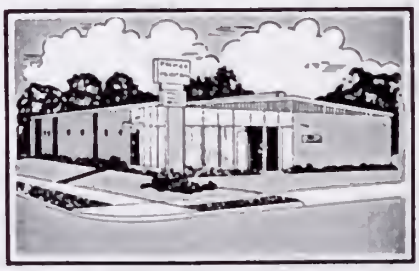
The results of the 1978 National Intern and Resident Matching Program (NIRMP) show more than half (54 per cent) of the 146 graduating medical students at the University of Mississippi Medical Center will take residency training in primary care areas. An additional eight students chose flexible or rotating internships, and a majority of these students will continue postgraduate study in primary care areas.

UMC graduates will claim 51 of the 76 first-year residency slots at University Hospital, and more than half (29) will be in primary care.

"Because of the nature of practice in the state, Mississippi graduates traditionally become primary care physicians," said Dr. Carl Evers, School of Medicine associate dean for student affairs at the Medical Center and MSMA president. "The physician shortage in Mississippi has always been more acute in rural areas—places where specialists are needed least."

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University Hospital interns include Cecelia G. Allred of Jackson, neurology (flexible); Mark F. Brooks of Hattiesburg, family medicine; Thais E. Brown of Jackson, family medicine; Charles L. Bryan of Meridian, internal medicine; Eugenia C. Bryan of Crystal Springs, pathology; Annyce R. Campbell of Mound Bayou, family medicine; Felton E. Combest of Greenville, family medicine; Anna C. Covington of Jackson, pathology; and Jefferson A. Fletcher of Jackson, internal medicine.

Also, Jack B. Foster of Hattiesburg, internal medicine; John P. Foster of Houston, family medicine; David George of Jackson, internal medicine; James B. Griffin of Jackson, obstetrics and gynecology; Mary P. Griffin of Tiplersville, pediatrics; Rebecca Hodges of Kilmichael, family medicine; Bruce Hollinger of Meadville, orthopedic surgery; Gerry Houston of Baldwyn, internal medicine; and Henry M. Jarmon of Vicksburg, surgery.

Other interns include Michael R. Johnson of Durant, family medicine; Thomas L. Keister of Jackson, psychiatry; Candace Keller of Laurel, surgery; Ronald Kent of Pascagoula, pediatrics; Larry Killebrew of Greenwood, surgery; Bruce W. Lambuth of McComb, internal medicine; George Lyon of Clarksdale, anesthesiology; Reb McMichael of Ocean Springs, psychiatry; and Gordon Meador of Jackson, pediatrics.

Also, James U. Morano of Jackson, radiology; Martha Murray of Liberty, psychiatry; Robert P. Myers of Hazlehurst, internal medicine; Barry D. Newsom of Jackson, surgery; James O'Donnell of Greenville, pediatrics; Clyde Phillips of Ward, AL, orthopedic surgery; Paul Press of Jackson, anesthesiology; Leonard Roberts of Brookhaven, family medicine; and Rudolph S. Runnels of Mize, family medicine.

Others are Kelly Seid of Greenville, family medicine; Charles G. Sherwood of Jackson, internal medicine; Julia Sherwood of Purvis, pediatrics; Glenn Smith of Coldwater, internal medicine; Robert Smith of Sardis, family medicine; Barry Sullivan of New Albany, internal medicine; John Tanksley of Clinton, orthopedic surgery; Stephen Tartt of Jackson, surgery; Robert Tarver of Walls, surgery; Mitchell Thomas of Cleveland, radiology; Charles Webber of Jackson, family medicine; Chester White of Fulton, obstetrics and gynecology; Daniel M. Woodliff of Jackson, internal medicine; and Jill Woodliff of Jackson, pathology.

Other new physicians filling the remaining University Hospital first-year positions come from the University of Alabama, the University of North

Carolina, Howard University in Washington, DC, Louisiana State University at New Orleans, Creighton University in Omaha, NE, Vanderbilt University and the University of South Alabama.

UMC Graduates 146 Physicians

Three hundred and six students in the health sciences received degrees in University of Mississippi Medical Center graduation exercises May 28 in Jackson.

The number included 146 for the M.D. degree, 36 more than last year. In 1974, the UMC School of Medicine received an increased state appropriation allowing the school to admit an additional 28 first-year students. The Class of 1978 is the first of the large medical classes to graduate.

Summa cum laude graduate James Ewell McDonald of Clinton earned the University's Leathers Award as the graduating medical student with the highest academic average. Other honor medical graduates included Walton Louis Moore of Booneville, Grayson Swayze Norquist of Yazoo City and Edward Eugene Rigdon of Heidelberg who received their degrees magna cum laude; and Jefferson Allen Fletcher and Barry Douglas Newsom of Jackson, Jack Byrd Foster, Jr., and Joseph Randall Moorman of Hattiesburg, Glenn Norman Smith of Coldwater and Barry Stephen Sullivan of New Albany, all of whom earned their degrees cum laude.

The UMC graduate number included 78 for the B.S. in nursing; 26 awarded the master of nursing; four, the master of combined sciences; three who received the master of science; four awarded the Ph.D.; 12 who earned a B.S. in medical record administration; 23 for the B.S. in physical therapy; and 10 awarded the B.S. in nurse anesthesiology

Commencement speaker was Dr. John Rhodes Haverty, dean of the College of Allied Health Sciences at Georgia State University. Chancellor Porter L. Fortune, Jr., conferred degrees. Other program principals included Dr. Norman C. Nelson, vice chancellor for health affairs and dean of the School of Medicine; Dr. Harvey Lewis, vice chancellor; Dr. Edrie J. George, dean of the School of Nursing; Dr. Thomas E. Freeland, dean of the School of Health Related Professions; Dr. Wallace V. Mann, dean of the School of Dentistry; and Dr. W. Lane Williams, assistant vice chancellor for graduate studies.

In Appreciation

The many fine technical exhibitors who participated in the exhibit during the recent Mississippi State Medical Association 110th Annual Session are deserving of our recognition and a hearty "Thank You!" Not only did the presence of these exhibits enhance the educational quality of our meeting, but the support provided by our exhibitors is essential to the continuance of our traditionally outstanding scientific program.

The firms listed below participated in our 1978 annual meeting exhibit and we voice a collective expression of our sincere appreciation. May we also suggest that you retain this listing and express your personal appreciation when their representatives call upon you.

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For additional information contact: John R. Reedy, Executive Director.



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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
July 1978, Vol. XIX, No. 7

ORIGINAL PAPERS

Factors Affecting Physician Participation in the Mississippi Medicaid Program

DEWEY D. GARNER, WINSTON C. LIAO, and THOMAS R. SHARPE
University, Mississippi

THE OVERALL GOAL of the Mississippi Medicaid program is to provide a portion of health care for the poor. It has been primarily economic in its approach. While it has attempted to reduce direct costs to the patient it has not attempted to deal directly with non-economic barriers to obtaining services such as the availability of services, continuity/convenience of care, and access mechanism.

Since the primary care physician directs patients into the health care system, his participation is essential to the success of the Medicaid program. If the physician does not participate in the Medicaid program proper care seems unattainable. The objective of this research, therefore, was:

> To determine what factors affect physician behavior with respect to acceptance and rejection of Medicaid patients.

A sample of 353 (23.2 per cent) physicians was selected from the 1521 medical practitioners in Mississippi in 1975 who provided direct patient care from an office-based practice. Their participation in the Medicaid program was determined by the dollar amount reimbursed to them by the Mississippi Medicaid Commission during the previous fiscal year. Of the 353 physicians, 177 were contacted in a telephone survey designed to assess the practice characteristics, attitudes, and behavior related to participation in the Medicaid program.

From the Department of Health Care Administration, and the Research Institute of Pharmaceutical Sciences, School of Pharmacy, The University of Mississippi. University, MS.

This was an exploratory study to determine what factors affect the behavior of Mississippi physicians with respect to acceptance and rejection of Medicaid patients. Physicians were asked to identify major advantages and disadvantages of the program to individual patients, to society, and to their medical practice. Nonparticipants were asked to identify the major reasons why they did not participate in the program. Medical specialty was found to be a significant demographic determinant of participation. Inadequate reimbursement, excessive paperwork, patient abuses of the program and bureaucratic complexity were among the most prominent factors contributing to nonparticipation.

Results

Of the 177 respondents, 92 (52.0 per cent) were in group practice while 80 (45.2 per cent) were in solo practice. Over half (96; 54.9 per cent) devoted more than six hours per day to their office-based practice. Only five (2.8 per cent) physicians cur-

rently were not accepting new patients whereas 172 (97.2 per cent) were. Most (94; 53.7 per cent) of the physicians saw daily an average of 30 patients or fewer, while 58 (32.6 per cent) saw between 31 and 50, and 23 (12.6 per cent) saw between 51 and 90 patients. Seventy (39.5 per cent) physicians said 5 per cent or less of their patients were Medicaid patients, 38 (21.5 per cent) said 6-15 per cent, 32 (18.1 per cent) said 16-25 per cent, 21 (13.0 per cent) said 25-49 per cent, and 14 (17.9 per cent) said 50 per cent or more.

Results of tabulations of physician responses regarding what they perceived to be the main advantages of the Medicaid program to individual patients revealed a relatively homogeneous set of opinions. There was a near consensus that the program offers medical care (access to the physician) for those who could not otherwise afford it. Among physician respondents 135 (76.3 per cent) indicated that this was a major advantage to the patient, representing more than twice the frequency of all other responses combined.

Physicians were far more heterogeneous in their perceptions concerning *disadvantages* of the program to individual patients. Many physicians (44; 24.9 per cent) felt that a major problem existed in that many doctors refuse to accept Medicaid patients, thus limiting patients' access to medical care. A number of respondents (20; 11.3 per cent) indicated also that the program is not realistically funded and physician fees are too low.

Excessive use of the program was an often-stated disadvantage as well, with 33 (18.6 per cent) physicians indicating this disadvantage. Other physicians (18; 10.2 per cent) indicated that poor quality care resulted because the financial structure of the program encourages high volume Medicaid practices ("Medicaid mills"). Yet with all of the above stated disadvantages 39 (22.0 per cent) of the respondents felt that there are no disadvantages of the program from the patient's view.

Over half of the respondents (51.4 per cent) suggested the program offers care (access to physician) for those who could not otherwise afford it. Approximately 20 per cent of the physicians felt the program offers no advantage to society and 10.7 per cent stated the program improves the general health of the community. The two most frequently suggested disadvantages were "patients abuse the program" (32.2 per cent) and "too expensive" (29.9 per cent). Approximately 20 per cent indicated the program was poorly administered, particularly in the area of eligibility screening. Three other categories were identified as disadvantages by approximately 10 per cent of the respondents: socialized medicine (federal encroachment into the health care system), dependence upon government (another free program) and lower quality of medical care.

The two most frequently suggested advantages of the Medicaid program to physicians' practices are that it offers some payment for the patients seen (32.2 per cent) and that it serves a humanitarian purpose (15.8 per cent). However, 76 (42.9 per cent) physicians perceived no advantages of the program to their practice. The most frequently voiced *disadvantage* was that of low reimbursement (62.7 per cent). Others included high or additional operating costs (28.2 per cent), excessive paperwork (25.4 per cent), high volume (22.0 per cent), patient abuse (17.5 per cent), bureaucratic complexities (13.6 per cent), and poor patient care (9.0 per cent). Only seven (4.0 per cent) physicians indicated that there were no disadvantages of the program to their practice.

When examining physician responses regarding overall what they like *best* about the Medicaid program, two responses dominated. Seventy (39.5 per cent) physicians liked best the access to care which the program provides to those who could not otherwise afford it. The other predominant response (51; 28.8 per cent) was that the respondent-physician liked nothing about the program.

Responses concerning what physicians overall like *least* about the Medicaid program were considerably more divergent, although a number of factors were clearly dominant. Problems concerning low fee schedules and unrealistic funding of the program in general, patient abuses of the program, and poor administration with excessive "red tape" and bureaucratization were identified by 82 (46.3 per cent), 40 (22.6 per cent) and 27 (15.3 per cent) physicians, respectively.

Related to perceptions of administration (conceptually, at least) were problems regarding excessive paperwork and administration of eligibility requirements for patients. Twenty-one (11.9 per cent) physicians indicated that the paperwork which participation required of them was an attribute of the program which they liked least. Similarly, 13 (7.3 per cent) physicians indicated that the eligibility requirements were not stringent enough and not monitored carefully enough to prevent patient abuses.

Four questions in the interview schedule were

answered only by the nonparticipants. These were designed to explore the reasons for nonparticipation, to determine what changes could be made in the program, if any, to convince the physician to be a participant and to determine how nonparticipants handle eligible patients who seek their medical services.

In response to the question, "Which of the following represent *major* reasons why you do not participate in the program?" 79 per cent indicated the reimbursement is too low. This was followed by: excessive paperwork (62 per cent), patients abuse the program excessively (62 per cent), it makes the government too involved in the delivery of medical services (56 per cent), the increase in patient load is more than your practice can handle (53 per cent), it is too expensive to the taxpayer (53 per cent), it demeans the patient (23 per cent) and other (5 per cent).

Since physicians were allowed multiple responses in the above question, they were also asked in the next question to identify the single most important reason for not participating in the program. Almost half (46 per cent) indicated the reimbursement is too low. This was followed by the increase in patient load is more than your practice can handle (16 per cent), the paperwork is excessive (14 per cent), it makes the government too involved in the delivery of medical services (12 per cent) and patients abuse the program excessively (11 per cent).

The most frequent response (60 per cent) of the nonparticipating physicians to the question, "What changes could be made in the program to convince you to become a participant?" was increase the fee (adequate reimbursement). Approximately 20 per cent of the respondents suggested get the government out (sponsor by private enterprise) or stricter controls to prevent program abuse would persuade them to participate. Two other responses, decrease administrative requirements (simplify paperwork) and stronger, more clearly defined eligibility criteria were cited by approximately 10 per cent of the respondents.

The question "How do you handle Medicaid eligible patients who seek medical services from you?" introduced the section of the interview schedule entitled, "Physician Behavior." The most frequent response was treat them for no pay (56 per cent). A close second was recommend another source of care (53 per cent). Thirty-one per cent indicated they treat them but require them to pay, and 25 per cent indicated they refuse to see them. Of those physicians who recommended another source of care 44 per cent recommended another physician, 21 per cent the hospital outpatient clinic, 15 per cent the county health department, and 7 per cent the hospital emergency room.

The structure of the Medicaid program with respect to referral patterns, laboratory procedures, and ancillary services basically does not alter the physician's treatment of Medicaid patients. Some physicians (24 per cent) indicated their treatment of Medicaid patients was somewhat affected in the case of prescribing patterns. This expression seems quite logical since the Mississippi Medicaid program does operate on a restrictive formulary.

The findings of the present study also show that more participants than nonparticipants tended to perceive no disadvantages of the program to individual patients; to respond that the program improves the general health of the community; to mention the program as being too expensive; and to state the advantage that it offers some payment for treating Medicaid patients.

The analyses also indicated a significant relationship between nonparticipation and voicing the disadvantage that many physicians would not accept Medicaid patients; mentioning that there are no advantages of the program to one's practice; responding that there was nothing that one could like best about the program; and citing "no change" with respect to one's prescribing patterns, referral patterns, laboratory procedures, and use of ancillary services.

Conclusion

Since the primary care office-based physician is usually the portal of entry into the health care system, it is essential that he or she participates if goals of Medicaid are to be achieved. This study has examined factors which may affect the behavior of Mississippi physicians with respect to acceptance and rejection of Medicaid patients. The findings indicate that certain demographic, attitudinal, and behavioral factors are related to Medicaid participation. While many of the results were anticipated, they serve to quantify, from the physician's perspective, his sentiments about the program. The study revealed that physicians were much more heterogeneous in their perceptions concerning the negative aspects of the program. The nonparticipants were considerably more vehement and a disproportionate number of them refused to participate in the study. ★★★

School of Pharmacy (38677)

A copy of the *Final Report* on this research project as submitted to the National Center for Health Services Research is available from the authors upon request.

Address of the President

JAMES O. GILMORE, M.D.
Oxford, Mississippi

THIS WEEK marks the end of my year as your president. I would be less than candid if I did not admit to mixed emotions about the event.

It has been an honor that Eula and I will cherish for the rest of our lives. We sincerely thank you for that.

During the year with your support the association has grown in stature and in its programs of service to the membership and public.

Much remains to be done, however, and I end my year as your president with a deeper appreciation of the potential of our federation of American medicine. Namely, our Mississippi State Medical Association, its component societies and the American Medical Association.

I want to share some thoughts with you today about that potential.

The major issues before our profession are public issues. We may not like that—but it is a fact and our response to the public issues that confront us will determine the future of our profession.

The issues generally concern cost of health care, access to health care and quality of health care. And they probably rank in that order with the public.

Now, we have two choices in addressing these issues. We can sit in our offices, see our patients, and pretend there are no public issues—or we can join together in a stronger federation of local, state and national effort to examine and positively respond to these issues as a profession.

Traveling over the state this past year as your president, I have been impressed by the growing number of physicians who recognize the public issues and are willing to participate in a positive response.

Those who appreciate the value and effectiveness of a strongly united local, state and national federation.

Those who appreciate that we can not accuse Washington of lacking faith in us if we lack faith in each other.

I am sure that our distinguished guest, Dr. Budd, will have something to say about the efforts of our federation on the national level. I will defer to him in that regard.

Let me tell you a brief story, however, which is illustrative of what is required on the state and local level.

A few weeks ago our state medical association went through a process of examining and commenting on a so-called "state health plan." The plan was formulated under requirements of Public Law 93-641, the National Health Planning and Resources Development Act.

We found much to comment about. Quite frankly, the plan lacked reality. In many respects it weakened quality medical care. So we commented and our comments were well received.

There was a return comment, however, from one of our audience who happens to be in public life. It was to the effect that you have logically torn the state health plan apart—I agree with everything you say—but what is your alternative?

What do we offer as alternatives? I think that question is before you at this House of Delegates meeting.

More particularly what are our alternatives for addressing the public issues of cost, access and quality that surround the practice of our profession today?

Thanks to the work of your Board of Trustees, councils and committees, you have some proposals before you in this regard for consideration at this meeting.

I would urge your careful consideration of recommendations from the Board and Council on Medical Service that we formulate a plan addressing quality, access and cost of health care in our state.

It will not be an easy task. It will require a blending of public-private, urban-rural initiative that has thus far not occurred in health planning in our state. I am confident, however, that we can succeed.

Concurrently with this effort I would hope that the association conducts the public opinion poll on health care recommended by the Board. This would

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President, Mississippi State Medical Association, 1977-78. Read before the House of Delegates, 110th Annual Session, Jackson, May 1, 1978.

be an independent, scientifically valid poll of what the public views as the strengths and weaknesses of health care in our state. I think the results will tell us where we need to direct our efforts to strengthen and improve our professional public relations.

Two years ago in Jackson this House of Delegates formally expressed its concerns about the manner in which Public Law 93-641 was being implemented in our state.

The political manipulation and self-interest of a few in the name of many involved in that effort was obvious to us.

We loudly called for an implementation of health planning in accordance with the intent of Public Law 93-641. Namely, health planning on a grass-roots basis and insulated from political manipulation.

Our voices were lost. We were alone with our concerns.

Today, our worst fears have been substantiated. The press contains almost daily accounts of the process. There are superficial local advisory councils and the real decisions are made in Jackson. There is a single state planning agency in the governor's office intertwined with a single health systems agency. There is great potential for political manipulation of the planning process.

So let us again state our concerns. Centralized direction and control from Jackson with respect to the public's health is no better than centralized direction and control from Washington.

Public Law 93-641 provides for local decisions on public health matters. Such decisions should be made by three or four health systems agencies geographically located over our state—not one health systems agency in Jackson. And the state's health planning activities should be located in a state agency insulated from the potential of political abuse.

Turning to another important matter, I urge your approval of a continuing medical education requirement as a condition for membership in the association. This ball is logically ours. Let's not give it up by inactivity. Our questions and concerns about CME can best be answered from within the profession.

You also have before you at this meeting an interprofessional code between our profession and the legal profession. The code represents a joint endeavor of a committee of our association and the Mississippi Bar Association. It seeks to improve our relationships with each other and with the public we both serve. I commend it for your endorsement.

Last but certainly most importantly, the Board has studied our historical relationship with Blue Cross-Blue Shield and is recommending that we endorse the Mississippi plan. Third party payment programs are assuming an even greater role in health care financing. We should seek to support the private sector in this regard as opposed to government third party programs. Blue Cross-Blue Shield offers us a voice in this growing process. I would hope that we accept the offer.

Let me close by saying that this has been an eventful year for our association, thanks to your efforts.

The Mississippi Medical Fraternal and Educational Society, which this House first approved in 1975, has grown from concept to reality. The society issued its first policies this past December and premiums are some 30-40 per cent lower than comparable coverage.

I am happy to report that we were successful this year in having the legislature provide for more reasonable reimbursement of physicians' services under Medicaid. Effective July 1, there will be a 40-50 per cent increase in the fee schedule.

The association has thus far successfully opposed efforts by those who would politically manipulate the State Board of Health. A suit by the governor and others in this regard was recently thrown out of federal court.

We have also continued to successfully oppose legislation by those who seek to practice medicine without benefit of a medical degree. A renewed effort will be required next year, however, because they will be back. They have nothing to lose and everything to gain.

Membership in the association has continued to grow and now exceeds 1,600 physicians.

We received an award last year for a numerical increase in AMA membership. The percentage of members belonging to the AMA remains at around 76 per cent. This is higher than the national average. I would hope that we would improve. Let us not wonder why there are those in Washington who would divide and conquer us if we are so divided we are conquerable.

Again, thank you for your support—your trust—and your confidence. Together, I know we will build a greater association at this 110th Annual Session. ★★★

2169 South Lamar (38655)

Radiologic Seminar CLXXXIII: Evaluation of Renal Mass Lesions

PHILIP E. CRANSTON, M.D.
Jackson, Mississippi

THE CENTRAL issue in renal mass lesion evaluation is the separation of tumor and cyst at an acceptable confidence level.[1] Benign cysts can be managed conservatively whereas life-threatening malignancies require radical surgery for cure.[2] Benign serous cysts are rarely of any clinical significance unless their expansion applies harmful pressure effect on the kidney. More importantly, they can be confused with renal tumors on the pyelogram by virtue of their mass effect. Autopsy data indicate one or more cysts in nearly half of the population 50 years or older.[3] Benign cysts make up 95 per cent of the asymptomatic renal masses detected by urograms. Since the advent of safer contrast media and better executed urograms, the identification of renal masses has increased.[1] Recently, it has been reported that about one of 10 patients undergoing CT abdomen scanning has had incidental renal cysts noted.[4]

Because of the increasing frequency of discovering these lesions and because these lesions are most frequent in elderly patients with their resultant higher mortality and morbidity rates, it is necessary to find a method of investigation that will produce a highly reliable diagnosis with a minimum in cost, time, and risk for the patient.[5] With the current level of public awareness in matters of health care cost and hospital utilization, it is necessary for physicians to include fiscal as well as medical considerations when planning patient care.[2] With this in mind, a basic approach is given in Figure 1.

The bulk of renal mass lesions will be initially detected by intravenous pyelography. A few can be first detected on plain abdomen x-ray; however, definite localization to the kidney will require urograms. As a rule of thumb, malignancies tend to cause more marked changes on the pyelogram than cysts, but reliable differentiation can not be made.[2]

After the presence of a mass is established by urogram, nephrotomography can be used for evaluation (see Figure 2). These studies are not pyelograms with tomograms but should be properly performed nephrotomograms. The linear tomography equipment that is needed is widely available. Accuracy has been traditionally accepted at 90-95 per cent for separation of cyst for solid lesion which is comparable with ultrasound examination. Recently Bosniak has re-emphasized the role of properly performed high dose infusion nephrotomography and quoted virtually 100 per cent accuracy when strict criteria for cyst diagnosis were applied.[6] It is doubtful that ultrasound should or will replace nephrotomography in the work-up renal mass lesions. Cases are reported demonstrating better accuracy with nephrotomography in certain type lesions.[2] Unless an allergic reaction has occurred, preference for ultrasound because of the use of contrast media in nephrotomography is not logical since the mass will be initially diagnosed from urograms.

Many feel that if a typical cyst pattern is demonstrated on nephrotomography, an acceptable endpoint has been reached. The criteria for a benign cyst are delineation of a thin wall, radiolucency throughout, and sharp interface with the renal parenchyma.[6] For 100 per cent certainty, cyst puncture can be used complementary and, in particular, for lesions felt to be cysts but which do not have all the listed criteria. If the lesion appears solid or to be necrotic tumor, then angiography is used for definitive study.

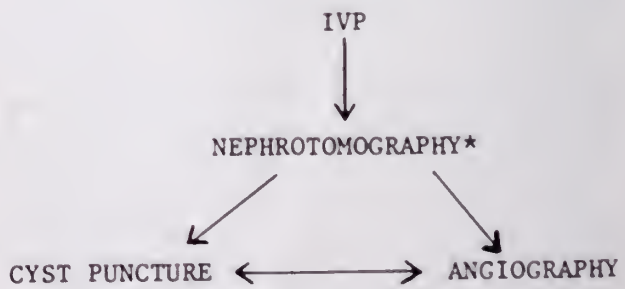


Figure 1

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, St. Dominic-Jackson Memorial Hospital, Jackson, MS.

* Ultrasound and/or CT scanning can be used instead of or with nephrotomography.



Figure 2. Nephrotomogram of a benign cyst. Note thin wall, relative lucency, and sharp interface with kidney.

Ultrasound and/or CT scanning have been more and more advocated for renal mass evaluation. Neither of these are yet universally available. Ultrasound has an accuracy of 90-95 per cent for separating cysts from solid lesions 2cm or larger.[7, 8] Current opinion is that a renal mass discovered incidentally and meeting all the classic CT criteria for a benign cyst, needs no further diagnostic evaluation.[4] The classic criteria are sharp interface with the renal parenchyma and typical water density CT numbers (see Figure 3). Accuracy for cyst definition is given at 100 per cent.[4] There are several advantages with CT scanning. First, a mass as small as .8cm can be detected. Second, scanning is completely automated and unlike ultrasound "the human hand" is not required for an adequate study, thus removing this omnipresent source of error. Third, it takes surprisingly little orientation on the part of the general radiologist and technologist in the use of this modality. The disadvantage presently is the cost for a CT study. CT head scanning has now proved indispensable and more fast head-body combination units will be available. The cost will accordingly decrease.

Renal cyst puncture is the ultimate step in benign cyst evaluation with accuracy approaching 100 per cent (see Figure 4).[1, 2, 5] The fluid will be clear yellow and cytology will be negative with benign cysts. Radiography of the contrast filled cyst will show a smooth wall throughout. There has been concern about the possible spread of tumor with inadvertent puncture of tumor; however, this occurrence should be rare. Comparative survival studies have not shown any difference between the aspirated group and the control group.[9] There has also been concern about possibly missing a cyst with a tumor nodule or tumor in the wall with non-surgical evaluation; however, these very rare lesions will most likely have positive cytology in the fluid. The natural history of self-healing hypernephromas is of uncertain clinical significance and the possibility of missing this lesion may well be unimportant as well as extremely remote.[4]

Angiography has assumed a reduced role in renal mass evaluation. In Pollack's study, this was only necessary in 13 per cent of the cases.[2] Angiography is indispensable for non-cystic lesions of the kidney. The accuracy is 95 per cent for renal neoplasm. In adenocarcinoma, the angiogram shows the typical increased vascularity of the malignancy (see Figure 5).

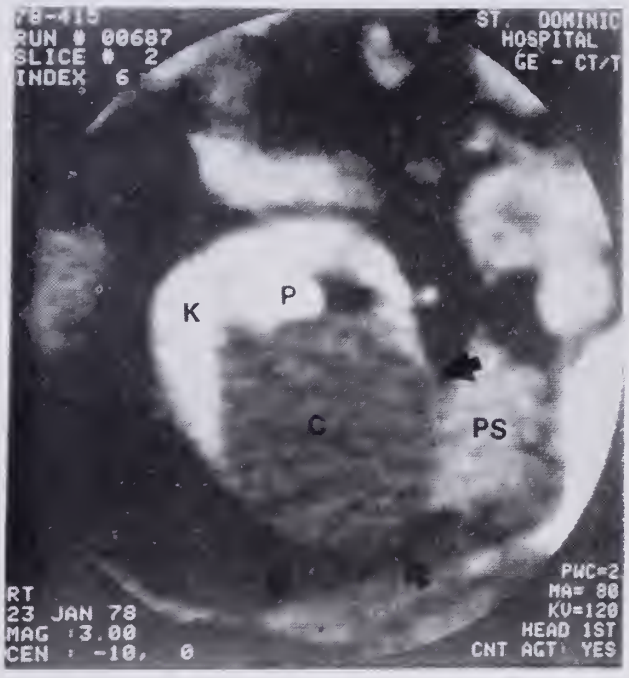


Figure 3. CT scan of a benign cyst. Note sharp interface with kidney, homogenous water density indicated by the CT number, and imperceptible wall. K—Kidney. C—Cyst. P—Pelvis. PS—Psoas.

Summary

An approach to renal mass evaluation is given. A practical low risk, low cost scheme should be maintained. The overwhelming majority of patients can be evaluated as outpatients. The present diagnostic modalities are considered complementary. A small



Figure 4. Renal cyst puncture. Note smooth wall of cyst. Fluid will be clear yellow and cytology will be negative.

percentage of patients will require all the various studies. An accuracy of virtually 100 per cent is achievable in patients where diagnosis can be rendered. Diagnostic exploratory surgery will be needed for the indeterminate lesions refractory to diagnosis. ★★★

969 Lakeland Drive (39216)

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Figure 5. Angiogram of renal cell carcinoma. Note typical hypervascularity of the lesion.

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The President Speaking

Where Are We?

CARL G. EVERS, M.D.
Jackson, Mississippi

A recurring question and point of debate for assessment at the recent meeting of the AMA House of Delegates revolved around the question of where we are in relation to control of rising health care costs. The goal of the Voluntary Effort is to slow the rate of increase of cost of hospital care, which was at a rate of 19-20 per cent per year, to a level slightly above the general economic growth rate of 10-11 per cent per year. Despite efforts of Secretary Califano to refute them, government figures from Bureau of Labor Statistics Consumer Price Index and from the Congressional Office of Management and Budget agree with the American Hospital Association, the Health Insurance Association of America and Blue Cross, all of which show these efforts are succeeding. For 1975-76, the rate of increase was 19+ per cent, but for 1976-77 this rate of increase had decreased to 15.6 per cent, and, most significantly, for the first quarter of 1978, was at slightly above 13 per cent. Thus, the goal for 1978 would seem to be obtainable. This is being done without compromising the quality of care, the key point of concern with both physicians and patients.

What these figures reflect is that physicians and hospitals have been paying attention to cost and that the current program merely formalizes and accentuates those efforts.

However, the Justice Department recently refused to encourage these efforts by not ruling on a request for clarification of anti-trust status of these voluntary efforts by hospital and physician groups, an action which upset certain members of Congress. The administration sees these efforts as a hindrance to a determined commitment to pass "cap" legislation.

This antithetical posture is not uncommon in government bureaucracy where HEW, the Department of Justice, and the Federal Trade Commission frequently disagree. While HEW insists the health professions assume responsibility for a number of difficult issues, the other agencies take the position that professional efforts imply professional control which they equate with professional monopoly. The FTC, in particular, argues that efforts to respond by changing the selection process, training activities, educational efforts, and practice patterns are all evidence of restraint of trade. They seem to believe that requiring a certain quality of training and level of competence are irrelevant, that physicians in particular should be able to advertise in whatever manner they wish, and that the public should be content to let the marketplace and the court decide on such issues as poor practice or false claims. To us these points of view seem ludicrous, but let us remember they are being pursued vigorously by non-elected individuals on the federal payroll.

We must continuously point out to the patient public that the prime goal of government efforts is to regulate and that in the name of regulation, the media are being flooded with "data" with figures which are often incomplete or erroneous, sometimes irrelevant, and usually subject to misinterpretation.

Perhaps the federal regulatory agencies should be high on a list of institutions which lack accountability and may be one of the largest offenders when considering monopolies.

The public more and more is viewing government efforts at social, educational, and health programs with skepticism. The recent results in California on voting on Proposition 13 is a solid indication of the patient public's mood. Public opinion polls reveal that the patient public clearly views voluntary cost controls as the most desired. A recent Harris poll revealed that 30 per cent of the public feel there is "too little regulation" of the hospital industry—a figure which is down significantly from the 49 per cent response last year and the 51 per cent response in 1974. These polls also revealed 60 per cent of the public feel that "no matter how good the social program, if it is run by government, it will always get messed up." This figure indicates somewhat less than a vote of confidence.

These same polls also indicate the public wants a bigger role in such specific areas as discussing alternative hospitals if admission is recommended, or additional medical opinions. Patients are not content with the status quo as they perceive it. With these wishes, hospitals and physicians have no quarrel.

At the same time that the health professions and the public are becoming increasingly alarmed by the power, ineffectiveness, inefficiency and waste of government programs, as never before the public is watching the medical profession. This surveillance is not only in the area of professional competence, but also as to whether and to what degree it will respond to perceived problems and needs.

Where are we? We seem to be at a turning point in the road. The question is not whether we will turn, but rather, to what degree. For the moment the ball seems to be in our field. We must continually reiterate that under our present system, we do receive the best medical care in the world. But we must also, individually and collectively, recognize that with the rights and liberties of the free enterprise system, there are responsibilities to respond to problems in that system.

We should recognize the public mood and the confidence which the patient public has in us, and, working together, respond to problems and needs without government intervention.

EDITORIALS

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VOLUME XIX, Number 7
JULY 1978

The Federal Trade Commission

One of the greatest threats to organized medicine as we know it today is the Federal Trade Commission. Recent expansion of the commission's statutory powers are having a direct impact on the health field. Specifically the Magnuson-Moss FTC Improvement Act of 1975 extended the commission's power to include: 1) jurisdiction over business entities whose activities affect interstate commerce; 2) the ability to attack deceptive acts and practices through trade regulations; 3) investigations of persons and partnerships as well as corporate entities; 4) representation by commission staff in Federal Court proceedings; and 5) assertion of civil penalties against all those who had notice of a commission cease and desist order proscribing particular deceptive acts and practices.

In addition to legislative changes, judicial decisions by the Supreme Court have likewise supported the FTC in its move against professionals. Specifically the Supreme Court's Goldfarb decision put an end to the so-called "learned profession" exemption. In other decisions the court has ruled that the practice of medicine does constitute a trade or commerce. The court also ruled that the dispensation of health care is not a local undertaking and is therefore subject to all federal regulations regarding interstate commerce. "Given the substantial volume of commerce involved, including direct federal government funding of Medicare and Medicaid, the growing participation of out of state third party insurers, interstate laboratory testing and diagnostic evaluations, commercial flow of drugs and medical equipment, and the inseparability of particular physicians services from the interstate aspects of health care generally, we conclude that interstate commerce has been sufficiently affected."

Fortified with these new regulations and judicial decisions, the FTC has now prepared and has begun its move against the medical profession. Specifically, the commission has issued consent orders barring some physician groups from using relative valuc scales. The staff of the Bureau of Competition regards physician-developed relative value scales as unlawful price affecting agreements. The application of codes of ethics by the American Dental Association and the American Medical Association is currently being challenged as an unlawful restraint on advertising and dispensation of information to the public regarding services rendered by physicians. The commission also supports and backs the development of health maintenance organizations (HMO's) and similar prepaid health plans. The commission is now involved in a nationwide investigation attempting to identify instances where individuals, hospitals, physician groups, or other organizations have attempted to block the development of such prepaid health plans and to take legal action against those exerting anti-competitive pressure on HMOs. In addition, the bureau will challenge state laws currently inhibiting development of such health maintenance organizations.

The commission also feels that a related factor contributing to the failure of insurers to control costs may be the dominance of Blue Cross-Blue Shield in the health insurance field since such plans are typically controlled or heavily influenced by physicians and physician groups, a normal incentive to impose effective cost controls may be blunted or distorted.

In April 1976, the commission began an investigation to consider various manpower issues involved in the health care field. First, the restrictions applied to allied health practitioners such as lab technicians are being reviewed. It is thought by some members of the commission that release of such allied practitioners and physician assistants from the direct supervision of M.D.'s and allowing them to establish private practices would lower the cost of health care since these services could be performed without involving the physician. Secondly, the commission is

examining the grounds on which some physicians are excluded from performing certain medical services by specialty groups that claim jurisdiction over those services. Third, the commission is considering the possibility that there may exist some artificial limitation on the numbers of physicians practicing with such restrictions being imposed by medical school accreditation practices. Specifically the commission is concerned that all accreditation review committees, and all residency review committees are physician controlled and constitute a conflict of interest. The bureau is also monitoring the development of professional standards review organizations to review the medical necessity and quality of medical services paid for by a federal program.

In a recent speech Halford F. Dougherty, Jr., director, Bureau of Competition, Federal Trade Commission, stated "Health care is a field which for some time was shielded from the application of antitrust principles. This situation has now changed, and there definitely are aspects in which we at the Bureau of Competition believe that antitrust enforcement can contribute significantly to dealing with the economic problems of health care markets. We are committed to a long term and varied effort to preserve and increase competition in these markets. I have outlined for you today the steps we have already taken and the areas in which we expect to focus our attention in the near future. You can expect both a strong enforcement program and a deliberate effort to test the boundaries of the law."

It is quite obvious that to the Federal Trade Commission the practice of medicine is a commercial enterprise rather than a learned profession, subject to the rules and regulations governing any other business. This simplistic view suggests that the health consumer would shop for the best price for his appendectomy or any other medical service on the assumption that an appendectomy is a standard package which could be delivered equally well by any physician. In a recent communication to the members of the American Council of Otolaryngology, Dr. Harry W. McCurdy, executive director, stated "The attack of the FTC on American medicine is by far the most serious threat to continued high quality health care in the land today. Not many physicians or patients understand that. Furthermore, there are many, many serious implications from this attack. That doctors are to be treated as tradesmen, there is no doubt. How then should the medical profession organize itself to respond to such conspicuously catastrophic change and what should be the tactics of this response? Very important questions, indeed, still to be understood and resolved."

MYRON W. LOCKEY, M.D.
Associate Editor

NEW MEMBERS

BALZLI, JOSEPH T., Vicksburg. Born Vicksburg, MS, June 24, 1948; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned UMC, Jackson, MS, one year; otolaryngology residency, same, 1974-77; elected by West Mississippi Medical Society.

GARROTT, THOMAS C., Biloxi. Born Blytheville, AR, Oct. 14, 1942; M.D., University of Mississippi School of Medicine, Jackson, 1967; interned Wilford Hall USAF, San Antonio, TX, one year; dermatology residency, same, 1969-72; elected by Coast Counties Medical Society.

HALL, DONALD S., JR., Vicksburg. Born Vicksburg, MS, Dec. 12, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned St. Mary's Hospital, Long Beach, CA, one year; ophthalmology residency, UMC, Jackson, MS, 1974-77; elected by West Mississippi Medical Society.

STRINGER, DOUGLAS L., Jackson. Born Wichita Falls, TX, Apr. 30, 1942; M.D., Medical College of Georgia, Augusta, 1967; interned U.S. Navy Hospital, Jacksonville, FL, 1967-68; surgery residency, Medical College of Georgia, 1971-72; neurological surgery residency, N.C. Baptist Hospital, 1972-77; fellowship, Canada, Jan. 1975-July 1975; elected by Central Medical Society.

SUMNERS, WILLIAM ELLIS, Booneville. Born Booneville, MS, Sept. 1, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned, same, one year; pediatric residency, same, 1972-74; elected by Northeast Mississippi Medical Society.

VANVINH, NGUYEN, Jackson. Born Hue, Viet Nam, Nov. 8, 1929; M.D., Saigon University, Viet Nam, 1960; interned, same, 1956-57; elected by Central Medical Society.

WATSON, DAVID G., Jackson. Born Toronto, Ontario, Canada, May 7, 1929; M.D., University of Toronto Faculty of Medicine, Toronto, Ontario, Canada, 1952; interned St. Michael's Hospital, Toronto, Can-


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ada, one year; pediatric residency, Hospital for Sick Children, Canada, one year; pathology residency, Children's Hospital, Michigan, July 1954-June 1955; elected by Central Medical Society.

WALLER, RICHARD E., Shelby. Born Lambert, MS, Mar. 25, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned UMC, Jackson, MS, 1974-75; elected by Clarksdale & Six Counties Medical Society.

WESSON, MATTHEW B., Tupelo. Born Evansville, IN, Feb. 3, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned St. Lukes Hospital, Denver, CO, 1971-72; ophthalmology residency, UMC, Jackson, MS, 1972-75; elected by Northeast Mississippi Medical Society.

DEATHS

SCHWARTZ, ROBERT E., Hattiesburg. Born Kentwood, LA, Oct. 3, 1898; M.D., Northwestern University Medical School, Chicago, IL, 1923; interned St. Louis City Hospital, St. Louis, MO, one year; medicine residency, Robert Koch Hospital, St. Louis, MO, 1924-28; died April 14, 1978, age 79.

POSTGRADUATE CALENDAR

Sept. 21-22, 1978
ALLERGY FOR THE GENERALIST
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine and the University Medical Center Division of Continuing Health Professional Education; the University of Tennessee Center for the Health Sciences College of Medicine; and the Vanderbilt University School of Medicine Division of Continuing Education.

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This two-day course for the generalist will be presented by a guest faculty. Fee: To be announced. Credit: 16 contact hours, 1.6 CEU, Category 1, AMA; AAFP.

FUTURE CALENDAR

Oct. 6-7, 1978
ADVANCED CARDIAC LIFE SUPPORT
University Medical Center, Jackson

Oct. 9-13, 1978
Jan. 8-12, 1979
PRACTICE OF ELECTROCARDIOGRAPHY
University Medical Center, Jackson

Oct. 26-27, 1978
ARTHRITIS SEMINAR
University Medical Center, Jackson

Nov. 10-12, 1978
FAMILY PRACTICE REVIEW
University Medical Center, Jackson

Dec. 2, 1978
DIAGNOSIS, TREATMENT AND REHABILITATION OF PATIENTS WITH UPPER ARM PROBLEMS
Methodist Rehabilitation Center, Jackson

All continuing education correspondence should be addressed to: Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216.

PERSONALS

PETER ASCANIO has set up his offices for the practice of general medicine at 502 A Cleveland Avenue in Gulfport.

WILLARD H. BOGGAN, JAMES P. HOLLOWAY and DWIGHT S. KEADY of Jackson announce the removal of their offices to Doctor's Hospital Medical Plaza, Suite 102, 2969 University Drive.

JOHN F. BUSEY of Jackson was elected first vice president of the Mississippi chapter of the American Lung Association at the 66th annual meeting.

MICHAEL C. DEBERARDINIS of Houston announces his practice limited to urology on Monday, Tuesday and Wednesday afternoons at Oktibbeha County Hospital in Starkville.

STANLEY HARTNESS of Kosciusko was elected from Attala County to the sub-area council of the Mississippi Health Systems Agency.

G. SWINK HICKS (general surgery) and JERRY W. ILES (family practice) announce the removal of their offices to Suites D and E, Doctors Building, 131 Jefferson Davis Boulevard in Natchez.

ALBERT RAY LEE, JR., announces the opening of his office at 1211 Magnolia Avenue in the Pittman Clinic for the family practice of medicine.

ARTHUR M. MARTIN, JR., has joined the staff of the Rush Medical Group in Meridian as a pathologist. He is certified by the American Board of Pathology in a pathologic anatomy, clinical pathology and radioisotopic pathology.

FRANK G. MARTIN has joined the Gulf Coast Surgical and Diagnostic Center, PA, Vancleave Road in Ocean Springs for the practice of surgery.

W. E. MOAK and E. H. COLE of Richton announce the association of JOHN C. NELSON in the practice of medicine at Richton Medical Center.

Recently appointed to the Mississippi Psychiatric Association Public Affairs Committee are WILLIAM C. MCQUINN of Jackson, chairman, GLEN ANDERSON of Brandon, CHARLES BELL of Whitfield, WALTERINE BELL of Whitfield, EDGAR DRAPER of Jackson, L. C. HANES of Jackson, NINA BESS GOSS-MOFFITT of Jackson, RICHARD RHODEN of Jackson, GERALD ROBERTSON of Hattiesburg, STEVE SMITH of Jackson, THOMASINA BLISSARD of Jackson, and CLIFF DAVIS of Gulfport. The committee has been established to develop and maintain effective communication with news media representatives.

MARCELO L. MORA announces the opening of his office for family practice at 101 Bank Street in Union.

LEO SCANLON of Vicksburg was guest speaker at the Vicksburg Kiwanis Club recently. His topic was forensic medicine.

JACOB MAHLON WILLIAMS of Burnsville has been appointed acting coroner of Tishomingo County. He is a pathologist.

LETTERS

SIRS: I would like to inform your readers of the fact that I have been appointed one of the 25 investigators regionally situated in the United States for participation in the Clinical Protocol for IND No. 2702 which is the protocol for Dow Corning MDX4-4011 medical grade injectable silicone fluid for soft tissue augmentation excluding the mammary area.

This program, which is being carried out by the Dow Corning Company in conjunction with the American Society of Plastic and Reconstructive Surgeons, is an effort to bring the advantages of medical grade liquid silicone injection to a select group of patients which might not be able to be treated by any other means. Examples of patients who would be eligible for this type of treatment are those with Romberg's hemifacial atrophy, lipocutaneous dystrophy, and major facial defects due to trauma.

This protocol specifically excludes the use of this material for augmentation of the breasts. As part of the protocol, no professional fee will be charged to any patient receiving this treatment. However, the patient will be responsible for the costs of x-rays, photographs, Xerograms, cost of the drug, associated expenses of injection, and paper work costs associated with treatment. In most instances the treatment can be carried out in the office; however, in younger patients it may be necessary to anesthetize the patient and perform the procedure in a hospital environment.

Specifically excluded from the study are those patients who are under six years of age and those females who are pregnant.

Should any of your readers have any questions as to the eligibility of possible candidates for this study, they can contact me by phone—(504) 899-1557, or write to me at 1477 Louisiana Avenue, New Orleans, Louisiana 70115.

WILLIAM J. POLLOCK, M.D., F.A.C.S.

THE LITERATURE

Book Review

Current Pediatric Diagnosis & Treatment, 5th edition. By Kempe, Silver and O'Brien. 1070 pages. Los Altos, CA: Lange Medical Publications, 1978. $17.00.

Current Pediatric Diagnosis and Treatment would seem to be helpful primarily to medical students, housestaff officers, generalists, and possibly to pediatric nurse practitioners. The authors' approach favors the broad overview and fails to provide a great deal of help for the experienced pediatrician faced with a diagnostic dilemma. The book is well arranged and quite readable generally. A great deal of information is presented. It is of interest that all the authors are currently or formerly members of the pediatric department faculty of the University of Colorado Medical Center.

O. WEIR CONNER, M.D.
Jackson, MS

MEDICAL ORGANIZATION

Medicaid Fee Increases Are Implemented in Mississippi

After seven years of operation, the first increase in physicians' professional fees under Medicaid was implemented in Mississippi this month. The change which resulted from passage of House Bill 647 during the 1978 Regular Session of the Mississippi Legislature will provide for about a 50 per cent increase in Medicaid professional fees.

When the Mississippi Legislature passed the Medicaid program in 1969 they provided for basically a fixed fee schedule for physicians' professional services consisting of the F-300 Blue Shield Surgical Schedule. A schedule for services not covered by the F-300 was to be developed by the Mississippi Medicaid Commission provided it was relative to fees authorized under the F-300 schedule.

Under House Bill 647 Medicaid payments were changed to the F-450 Blue Shield Surgical Schedule which is generally 50 per cent higher than those in the F-300.

Complete details of the change in Medicaid payment have been mailed to all physicians.

MMFES General Manager Is Named

The Board of Directors of the Mississippi Medical Fraternal and Educational Society has announced the appointment of Michael D. Houpt as the general manager of the society.



Mr. Houpt

"Mike" who formerly was with United States Fidelity and Guaranty Insurance Company's office in Jackson is a native of Ridgeland, Mississippi. He graduated with a B.S. degree in Business Administration from the University of Southern Mississippi and for the past several years has been a claims adjuster with USF&G.

Dr. Faser Triplett, president of MMFES, stated on behalf of the Board of the society with regard to Mike's employment, "We are pleased to employ a person with Mike's background to assume the important administrative tasks of the society.

Medico-Legal Brief

MD Has No Claim Against Attorneys for Settling Suit

A physician whose attorneys accepted voluntary discontinuance of a malpractice suit had no claim against the attorneys for depriving him of a judicial determination of the malpractice complaint, a New York appellate court ruled.

A neurosurgeon was sued for malpractice by the estate of a patient. He moved for summary judgment on the grounds that he had not been the treating physician, only an emergency consultant, and that his diagnosis was correct and proper. Before the hearing on the summary judgment motion, the estate offered to discontinue the action against the physician. The physician refused to consent to the proposal, but his insurance company and its attorneys accepted the discontinuance.

A few months later the physician filed suit against his insurance company and its attorneys for breach of the insurance contract in accepting the discontinuance without his consent. He claimed he was deprived of judicial vindication and sought damages for injury to his professional reputation, emotional trauma and impairment of his right to pursue his remedy for abuse of process and malicious prosecution. A trial court dismissed the suit, and the physician appealed.

Affirming the decision, the appellate court said that the physician had no right to have a judicial determination on the malpractice suit. The attorneys' acceptance of the discontinuance was tantamount to successful termination of the action in the physician's favor, the court said.—*Aquilina v. O'Connor,* 399 N.Y.S.2d 919 (N.Y.Sup.Ct., App. Div., Dec. 8, 1977)

Medical Center Holds Commencement Exercises



Dr. John Rhodes Haverty, second from right, delivered the Commencement address in University of Mississippi Medical Center graduation exercises May 28. Dr. Haverty is dean of the College of Allied Health Sciences at Georgia State University. With him are, from left, Dr. Verner Holmes of McComb, president of the Board of Trustees, State Institutions of Higher Learning, University of Mississippi; Chancellor Porter L. Fortune, Jr., and Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean.

Annual Thoracic Meeting Hears Boswell Lecture



The 23rd annual meeting of the Mississippi Thoracic Society and the fifth Henry Boswell Lecture, combined for the first time, were held recently in the Oglevee Auditorium, University Medical Center in Jackson. Mississippi Thoracic Society officers for the coming year are (from left) Dr. Richard T. Furr, Ocean Springs, outgoing president; Dr. G. Boyd Shaw, Jackson, MTS representative councilor to the American Thoracic Society; Dr. John D. Morgan, McComb, secretary-treasurer; Dr. Dwight S. Keady, Jackson, president-elect; and Dr. Joe R. Norman, Jackson, president. The theme of the session was Mechanical Ventilation Update 1978 and the meeting was co-sponsored by the Mississippi Lung Association, the Mississippi Thoracic Society, the University of Mississippi School of Medicine and the Medical Center Division of Continuing Health Professional Education.

Medical Center Hosts Boswell Lecturer



Dr. H. Barrie Fairley, center, professor and vice chairman of the Department of Anesthesia at San Francisco General Hospital, was the 1978 Boswell Lecturer at the University of Mississippi Medical Center. With Dr. Fairley are, from left, Dr. Richard T. Furr of Ocean Springs, president of the Mississippi Thoracic Society, and Dr. Joe R. Norman, UMC professor of medicine and director of the pulmonary diseases division, and the Mississippi Lung Association Christmas Seal professor of respiratory diseases. The lecture, part of the yearly Mississippi Thoracic Society meeting, is sponsored by the Mississippi Lung Association, the Mississippi Thoracic Society and the University of Mississippi School of Medicine. The late Dr. Boswell was the first and only superintendent of the Mississippi State Sanatorium at Magee.



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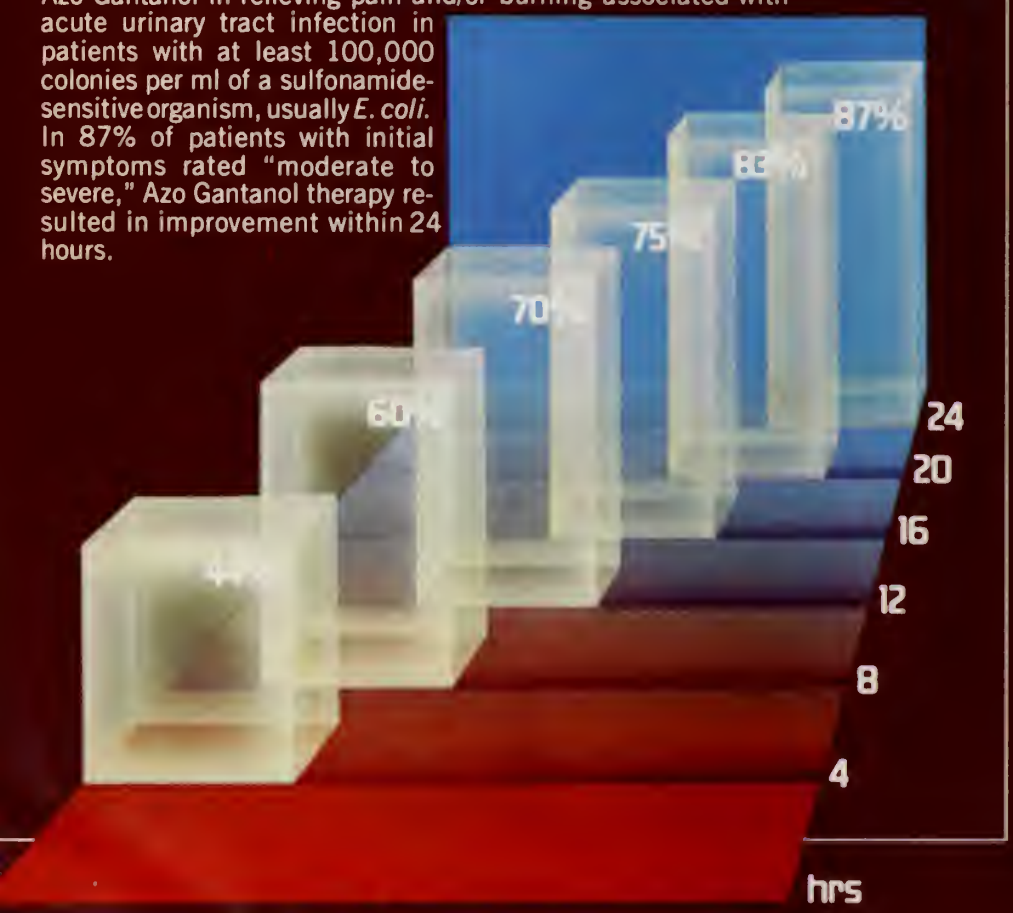
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Important data on the pain of acute cystitis:

In 87% of patients studied [303 of 349], Azo Gantanol® reduced pain and/or burning within 24 hours*

A controlled, multicenter study assessed the efficacy of Azo Gantanol in relieving pain and/or burning associated with acute urinary tract infection in patients with at least 100,000 colonies per ml of a sulfonamide-sensitive organism, usually *E. coli*. In 87% of patients with initial symptoms rated "moderate to severe," Azo Gantanol therapy resulted in improvement within 24 hours.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I disturbances.

Warnings: Safety during pregnancy not established Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

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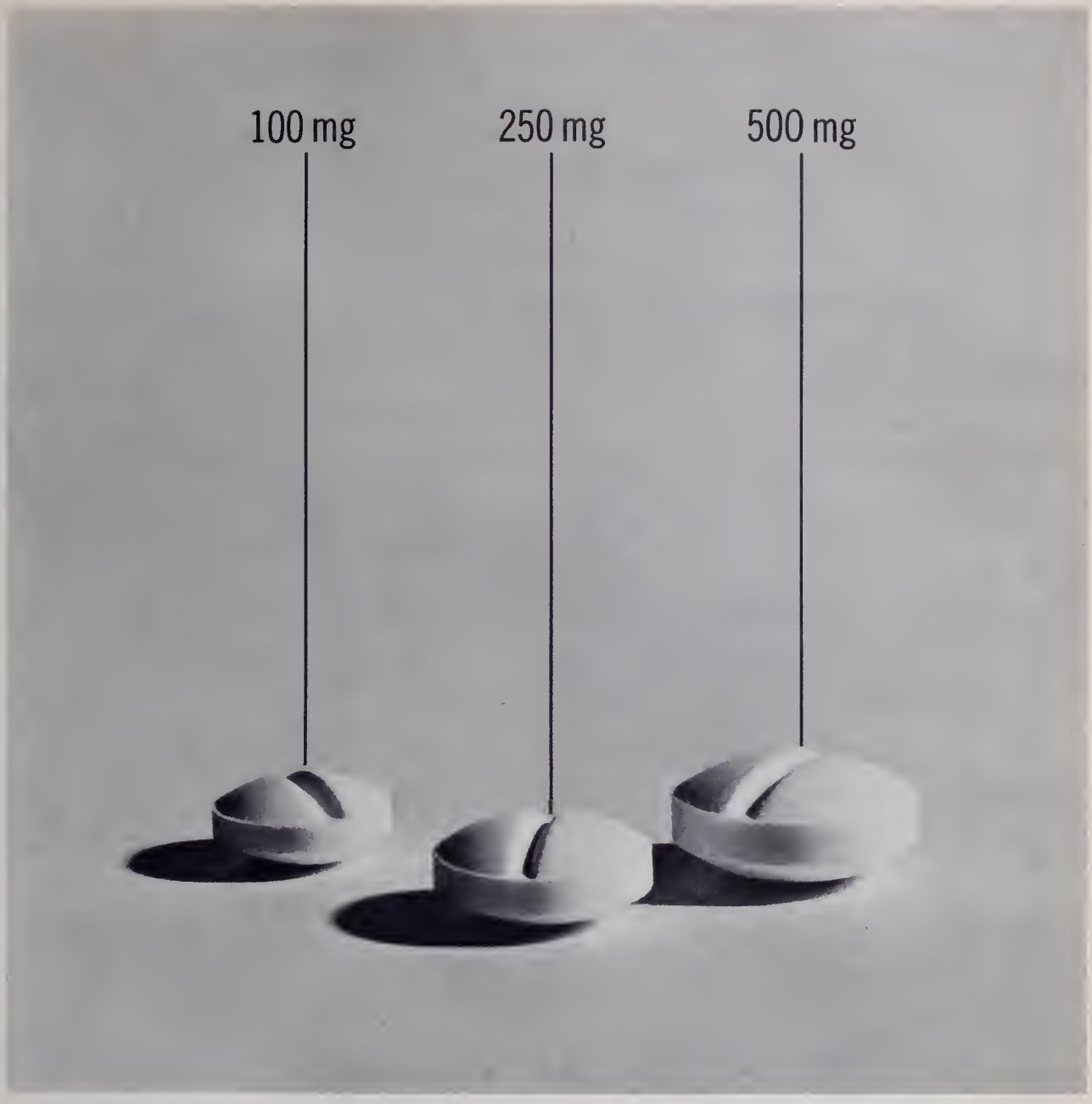
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J. E. McDonald Is UMC's Top Graduate



Summa cum laude graduate James Ewell McDonald of Clinton, left, earned the University of Mississippi School of Medicine Leathers Award as the graduating student with the highest academic average. A dean's scholar and president of Alpha Omega Alpha, the young physician has been recipient of the school's Alford Memorial Award, the Collins Foundation Award, the Goodpasture Award, Sandoz Award, Upjohn Award and a Lange Book Award, all given for academic excellence. With Dr. McDonald, who will intern at Charity Hospital of Louisiana, is UMC Vice Chancellor for Health Affairs Dr. Norman C. Nelson.

Medical Science Redefines Thinking on What Is Normal

Physicians in the 1970s are having second thoughts about what is normal. As the science of genetics has progressed, medicine has learned that just about anyone may carry mutant genes. This doesn't mean he or she is sick, but that there are variations in the genes.

Drs. Robert B. Scott and Robert P. Gilbert of the Medical College of Virginia, Richmond, in a special communication in the June 23 *Journal of the American Medical Association* point out that "Genetics is no longer an esoteric discipline, but is now having an effect on the practice of every physician."

Testing for genetic traits now includes a total of nine categories of hereditary diseases, the best known of which is sickle cell anemia. Others include cystic fibrosis, hemophilia, Huntington's chorea, and muscular dystrophy.

Genetic testing permits couples to know in advance the risk of giving birth to a malformed child.

"The problem," say Drs. Scott and Gilbert, "is in the public conception of 'blood tests' and 'abnormal results.' When a laboratory result is stated to be anything other than 'normal,' the reaction is 'there must be something wrong with me.' "

In the case of mutant hemoglobin genes, there are many instances where the gene may be abnormal (a mutant) but no disease is produced, they point out. But, "The person being counseled has difficulty in accepting this. It is as difficult to convince some persons that they are healthy as it is to educate others concerning their genetic disease."

"This counseling problem will persist until there is a new understanding among physicians and the public that 'normal' includes a great deal of diversity."

This diversity will become more and more evident as new screening programs are implemented in the future, they say.

UMC Hosts Advanced Cardiac Life Support Course



More than 35 physicians from three states participated in a University of Mississippi Medical Center advanced cardiac life support course in May. Co-directors were from left, Dr. Thomas J. Herrin, UMC associate professor of anesthesiology, and Dr. William W. Bradford, emergency room physician at Singing River Hospital in Pascagoula. The course was sponsored by the UMC Department of Anesthesiology and the Medical Center Division of Continuing Health Professional Education in cooperation with the Mississippi Heart Association. With them at one of the eight life support performance stations is Dr. Charles Hubbert of Memphis.

Counsel to Authors

THE JOURNAL welcomes manuscripts which should be submitted to the Editors at 735 Riverside Drive, Jackson, MS 39216, in original and at least one duplicate copy. They must be typewritten double spaced on 8½ by 11-inch white paper. **Brief manuscripts (about 2,500 words or 8 pages) will be given preference over longer articles.**

The author is responsible for all statements made in his work, including changes made by the manuscript editor. Manuscripts are received with the understanding that they are not under simultaneous consideration by any other publication and have not been previously published. All manuscripts will be acknowledged, and while those rejected are generally returned to the author, the JOURNAL is not responsible in event of loss. Manuscripts accepted for publication become the property of the JOURNAL and are copyrighted by the association when published. They may not be published elsewhere without written release and permission from both the JOURNAL and the author.

All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

Illustrations consist of all material which cannot be set into type such as photographs, line drawings, graphs, charts, and tracings. Illustrations should be submitted separately from text copy. Figures and drawings should be professionally prepared with black ink on white paper. Photographs should be of high resolution, unmounted, untrimmed, glossy prints. Each must be clearly identified. No charges are made to authors for up to four illustration engravings. More are not permitted unless voted on by two editors and extra costs must be absorbed by the author.

Illustrations must be numbered and cited in the text. Legends, not exceeding 40 words and preferably shorter, must accompany each illustration, typed double spaced on separate sheets. The following information should appear on a gummed label affixed to the back of each illustration: Figure number, manuscript title, author's name, and arrow indicating top of the illustration.

In photographs in which there is any possibility of personal identification, an acceptable legal release must accompany the material.

A thesis summary of 75 to 100 words must accompany each manuscript.

Reprints may be obtained at cost plus shipping charges from the association and **should be ordered prior to publication.** The JOURNAL reserves the right to decline any manuscript. Authors should avoid placing subheads in the text, and the Editors reserve the prerogative of writing and inserting subheads according to JOURNAL style. —*The Editors.*

Epilepsy Rate Is High Among Prison Inmates

There is three times as much epilepsy among prisoners in Illinois jails and prisons as among the population at large, says a report in the June 23 *Journal of the American Medical Association.*

Drs. Lambert N. King and Quentin D. Young of Cook County Hospital, Chicago, made a survey of 12,030 persons in 10 Illinois correctional institutions. Seizure disorders were found in 1.9 per cent, approximately three times the rate among middle class nonprisoner populations.

"Special programs and resources for the detection, treatment, and prevention of seizure disorders among prisoners appear necessary. Provisions to ensure continuity of care after release from incarceration are also needed," say Drs. King and Young.

In an editorial in the same issue, Dr. Maurice W. Van Allen of University of Iowa Hospitals, Iowa City, points out:

"The occurrence of organized antisocial behavior attributable directly to epilepsy is uncommon, and conviction for an unidentified crime is even more so. However, other circumstances may make the epileptic more likely to appear in court and in prison than the average citizen."

Society discriminates against the epileptic, Dr. Van Allen says, and "The epileptic's withdrawal and feeling of rejection, combined with the prejudice he experiences throughout his maturation, lead to inadequate educational, matrimonial, and employment opportunity. His self-esteem may be low, and his choice of companions and associates may come from those with emotional, mental, or physical handicaps of their own. Alcoholism and drug use may follow.

"Is it any wonder that, having been pushed down into a group of low personal and social expectation, the epileptic may occasionally end up in prison?"

Epileptics are more poorly served medically and socially than with any other large category of patients, Dr. Van Allen declares, but new programs are now under way that may improve the situation.

"The American Medical Association is to be congratulated for undertaking its own program to improve the care of the imprisoned. The best possible understanding and care of the confined epileptic is one facet of this."

CLASSIFIED

OFFICE SPACE AVAILABLE for one to three physicians in Jackson, Tennessee, population 50,000. Space suitable for family or specialty practice and is located across the street from two hospitals, and is available July 1, 1978. Reply to: S. M. Hillhouse, c/o The Doctors' Clinic Building, Inc., 686 West Forest, Jackson, TN 38301.

FAMILY PRACTICE PHYSICIAN—University of Mississippi graduate '76, 3rd year resident, available August '79. Contact Richard Carter, Jr., M.D., 2208 S. Jefferson Street, Apt. C 4, Roanoke, VA 24014. Phone 703-982-3754.

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Index to Advertisers

Air Force 8
Burroughs Wellcome Co. 144D
Canton Exchange Bank 3
Citizens Bank and Trust Co. 10
Coca-Cola 3
Dermik Laboratories second cover
Doctors Needed 11
Family Practice Physician 19
Harreld Chevrolet-Oldsmobile 14
Hill Crest Hospital 12
Eli Lilly and Co. 14A
Mead Johnson Laboratories 140A, 140B
Miss. Stationery Co. 15
Office Space Available 19
Pennwalt Corp. 14B, 14C
Premier Printing Co. 16
Riverside Hospital 18
Roche Laboratories 6, 7, 144B, third and fourth covers
Smith Kline and French 144A
E. R. Squibb and Sons, Inc. 10A, 10B
The Upjohn Company 144C
Thomas Yates and Co. 4

IN CONCLUSION

The combined results of drugs, environmental pollutants, alcohol and disease have seemed to center on one hard-working but beleaguered organ, the liver, according to researchers at the University of Texas Health Science Center at Dallas. In less than 10 years liver diseases in the U.S. are predicted to rise from fifth to third place as a cause of death. And since death from liver diseases is often preceded by prolonged illness requiring frequent hospitalization, it is a serious problem for society, says Dr. Burton Combes, liver researcher at UT.

Emerging from the national outcry against soaring health care costs is a growing realization that family practice--by its very nature--represents the most efficient and economical type of health care delivery, according to the American Academy of Family Physicians. The family practice approach to health care delivery discourages the trend toward "over-delivery of health care" and at the same time plays a significant role in health costs containment, says AAFP. The focus is on disease prevention and health maintenance of the family as a whole on a continuing basis.

Injury rates for high school girls in interscholastic sports are no greater than those for boys in the same games, says a report in the May 26 JAMA. The division of sports medicine of the University of Washington, Seattle, reported on a study of four girls' high school athletic programs for two years. Some 22 per cent of the girls were injured each season, they reported. Injury ratio for players on the schools' boys' teams in those same sports was 24 per cent. Most injuries were minor, including strains and sprains.

Sen. Edward Kennedy and organized labor have sent a "Private Guaranteed Plan" for national health insurance to the White House. The plan would guarantee universal health coverage for every American and would give private health insurance companies and HMO's major roles. A reinsurance pool would pick up catastrophic health care costs. Estimated cost is between $171.5 billion and $182 billion. This plan would be phased in based on hospital reviews and fee schedules negotiated between third party insurors and physicians.

"Basic research is alive and well in the Carter Administration," emphasized Dr. S. Omenn at a public affairs symposium on the administration's view of basic research and the life sciences. Dr. Omenn, Assistant Director of the President's office of Science and Technology Policy, explained President Carter's expressed desire to support basic research while at the same time simplifying government's role to something less than regulation. FDA expressed concern that consumer groups are demanding more protection for the public while animal welfare groups want a reduction in animal testing.

Before prescribing, please consult complete product information, a summary of which follows:

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient

Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients, should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures

INJECTABLE *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V. inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist, use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence, can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm, increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic; have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance

INJECTABLE Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value

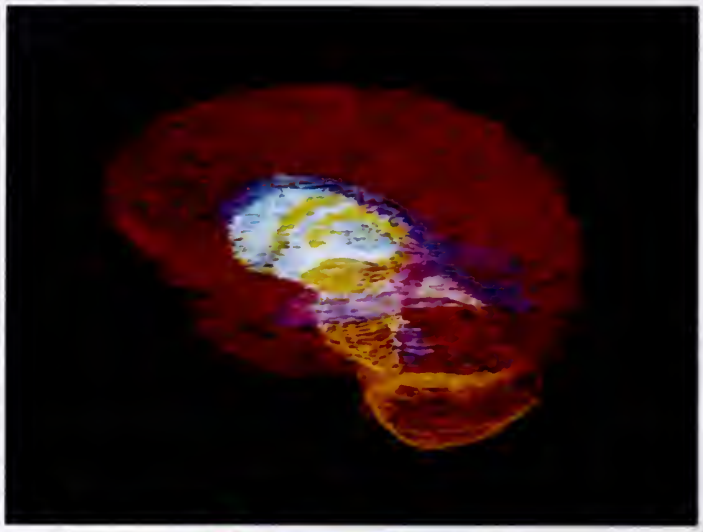
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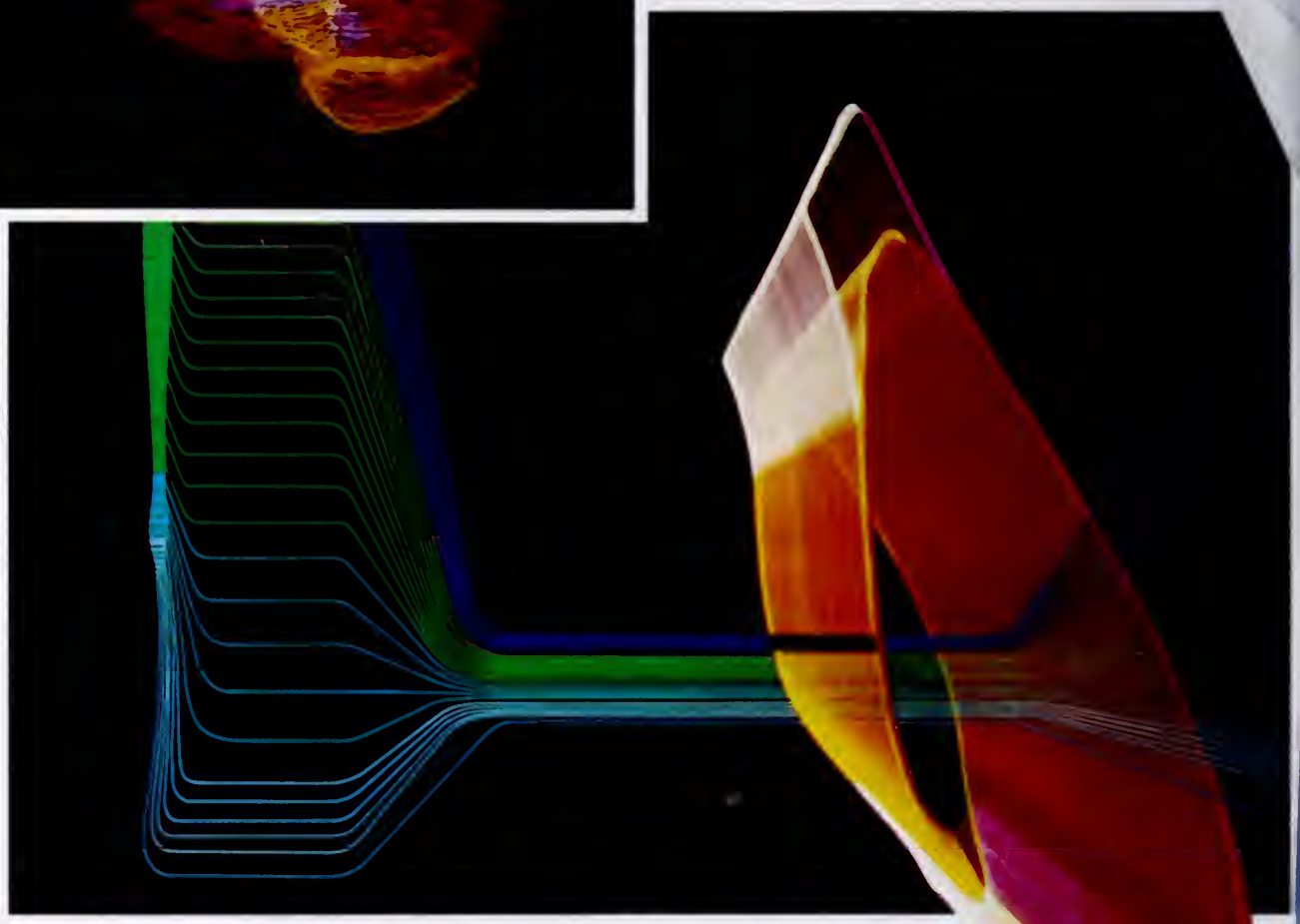


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Journal of the State Medical Association

Mississippi



Contents:

Emergency Treatment of Shock—Use of Medical Antishock Trousers (MAST)

The State Board of Health Manpower Project

Front Runner



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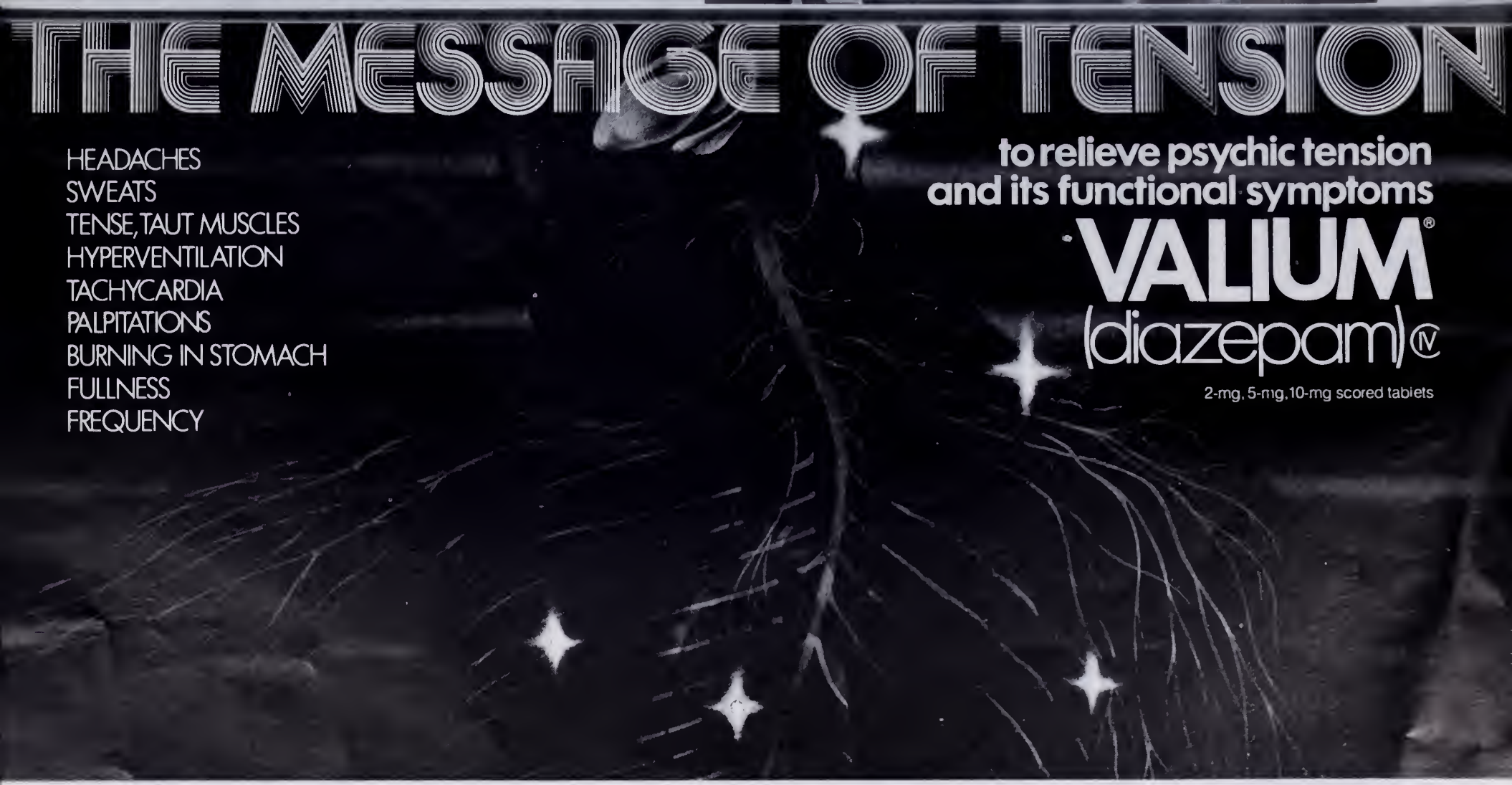
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The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy

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CONTENTS

ORIGINAL PAPER

Emergency Treatment of Shock—Use of Medical Antishock Trousers (MAST) 147 Robert R. Lowe, M.D., Jackson, MS

SPECIAL ARTICLE

The Health Manpower Project 151 Mark Lynch, Jackson, MS

EDITORIAL

It's Your Journal 157 W. Moncure Dabney, M.D., Crystal Springs, MS

THIS MONTH

Auxiliary Page 155 Mrs. G. Samuel Rowlett, Vicksburg, MS

The President Speaking 156 AMA Encourages New Blood

Medical Organization 160 MMFES Reports Phenomenal Growth

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Canadian Doctors Move to U. S.

The flight of general practice doctors from Canada to the United States continues to increase, bringing demands for government action to stop the flow.

Last year, 733 doctors left Canada, 145 more have left the first three months of this year, and—according to immigration applications—the total exodus for 1978 could reach 1,500. That's only slightly below the total number of doctors graduated annually from Canadian universities.

The clamor is on to stir the federal government into action. Max Saltsman, a member of Parliament for Waterloo-Cambridge in Ontario, says that perhaps Canada should follow the Soviet lead and require highly trained university graduates to pay back what their education cost the country if they leave before exercising their skills for a reasonable length of time in their country.

Dr. Paul Yewchuk, a member of Parliament from Alberta, says money isn't so much the problem as the way governments harass doctors by publishing their earnings and tightly controlling fee schedules while lawyers and dentists are free to set their own fees.

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AMA President Urges Fee Limits

The new president of the American Medical Association has called on physicians to voluntarily hold down the rate of increase in their professional fees.

Acknowledging that AMA leaders in the past have been "loathe to discuss" this "forbidden ground," Dr. Tom E. Nesbitt called on doctors to limit increases to one per cent a year.

He said such a restraint would bring the rate of increase in physician fees in line with the overall rate of increase in the Consumer Price Index by 1980.

The current rate of increase in physician fees is 9.2 per cent. He attributed the 13 per cent increase in doctors' fees from 1975 to 1977 to a "catch-up period" for physicians, following the wage and price controls imposed in the early 1970's.

He said there was no formal plan to implement the fee restraint program but tied it to the voluntary campaign to restrain costs sponsored by the AMA, the American Hospital Association, and the Federation of American Hospitals.

UMC Will Host Allergy Seminar

Eight physicians will be guest faculty for a seminar on allergies at the University of Mississippi Medical Center in Jackson Sept. 21-22.

Sponsors for the annual conference are the University of Mississippi School of Medicine and Division of Continuing Health Professional Education, the University of Tennessee Center for the Health Sciences College of Medicine and Vanderbilt University School of Medicine Division of Continuing Education. Each school hosts the seminar on a rotating basis.

This year's conference coordinator is Dr. Bernard Booth, clinical associate professor of medicine at the Mississippi Medical Center.

Guest faculty from the University of Tennessee Center for Health Sciences College of Medicine in Memphis includes Dr. Lloyd Crawford, clinical professor of pediatrics and chief of the allergy section, department of pediatrics, and Dr. Phillip Lieberman, associate professor of medicine and chief of the section of allergy—immunology, department of medicine.

The guest faculty also includes Dr. Elliott F. Ellis, professor of pediatrics and department chairman at the University of New York in Buffalo; Dr. Samuel R. Marney, associate professor of medicine and head of the allergy section at Vanderbilt University School of Medicine in Nashville; Dr. Raymond G. Slavin,

professor of internal medicine and director of the allergy and immunology section at St. Louis University Medical School; Dr. W. W. Taylor of Memphis; and, from the Mississippi Medical Center, Dr. Joseph H. Robinson, clinical assistant professor of medicine (dermatology) and Dr. Louis J. Wise, clinical associate professor of medicine (dermatology).

Course fee is $85.00. Credit is 16 contact hours, AMA Category 1 and American Academy of Family Practice.

For more information, contact Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216.

GAO Says JCAH Is More Effective Than HEW

The General Accounting Office may recommend to Congress in an upcoming report that the Joint Commission on Accreditation of Hospitals be given sole power over hospital accreditation nationwide.

Currently, the Department of Health, Education, and Welfare is responsible for about 1,800 hospitals which either fail or don't apply for JCAH accreditation. HEW delegates this function through state validation of hospitals that participate in the Medicare program. It spends about $6 million yearly.

The GAO report is significant because a 1976 HEW report to Congress found that about 70 per cent of a sample of hospitals which were accreditated by JCAH would have failed the HEW validation process. This led to charges by critics that JCAH is overly biased in its surveys toward the hospitals and should be replaced by a less subjective unit—namely the government. The GAO will dispute this criticism.

Medical Assistants Hold Annual Meeting

The American Association of Medical Assistants, Inc., Mississippi Society, held its 12th annual state convention at the Ramada Inn in Greenwood, April 28-30. Of the 164 registered, 101 were medical assistants. Theme of the convention was Education + Dedication = Certification.

General officers elected for 1978-79 are Mrs. Ethel Tatum, Meridian, president; Mrs. Glenda Jenkins, Meridian, vice president; Mrs. Gladys Lamb, Greenwood, secretary; Mrs. Helen Donohoo, Gulfport, treasurer; and Mrs. Marian Cook, Tupelo, president-elect. Members of the executive board are Miss Carol Lockey, Jackson, and Mrs. Jackie Balducci, Clarksdale.

State advisors appointed by MSMA are Drs. Guy Campbell, Jackson, and Richard Burman, Gulfport.

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Physicians elected by the AAMA-Miss. Society executive board are Drs. William T. Oakes, Amory; Dan Thornton, Meridian; and Edwin Hemness, Clarksdale.

Guest speaker for the Saturday evening banquet was Dr. Carl Evers of Jackson, MSMA president-elect and associate dean of UMC.

Miss Jean Mobley, CMA-AC vice president, AAMA, Lubbock, TX, installed the new officers and conducted the educational workshop, "Positive Communications Skills and Problem Solving," which had been approved for 0.2 CEU credits.

Malpractice Insurance Is Profitable

The St. Paul Insurance Company has announced its 1977 losses and earnings on medical practice insurance. Subtracting all claim cost and expenses incurred in 1977, St. Paul reports a pre-tax profit of $12.9 million on premium income of $130.5 million.

St. Paul recently announced a 20-25 per cent rate reduction in its excess coverage policy offered to physicians in Mississippi. At the same time the company reported that it would now offer a single $1,000,000 excess coverage policy to physicians seeking such coverage instead of the basic $100,000/300,000 policy and separate excess coverage policy offered before.

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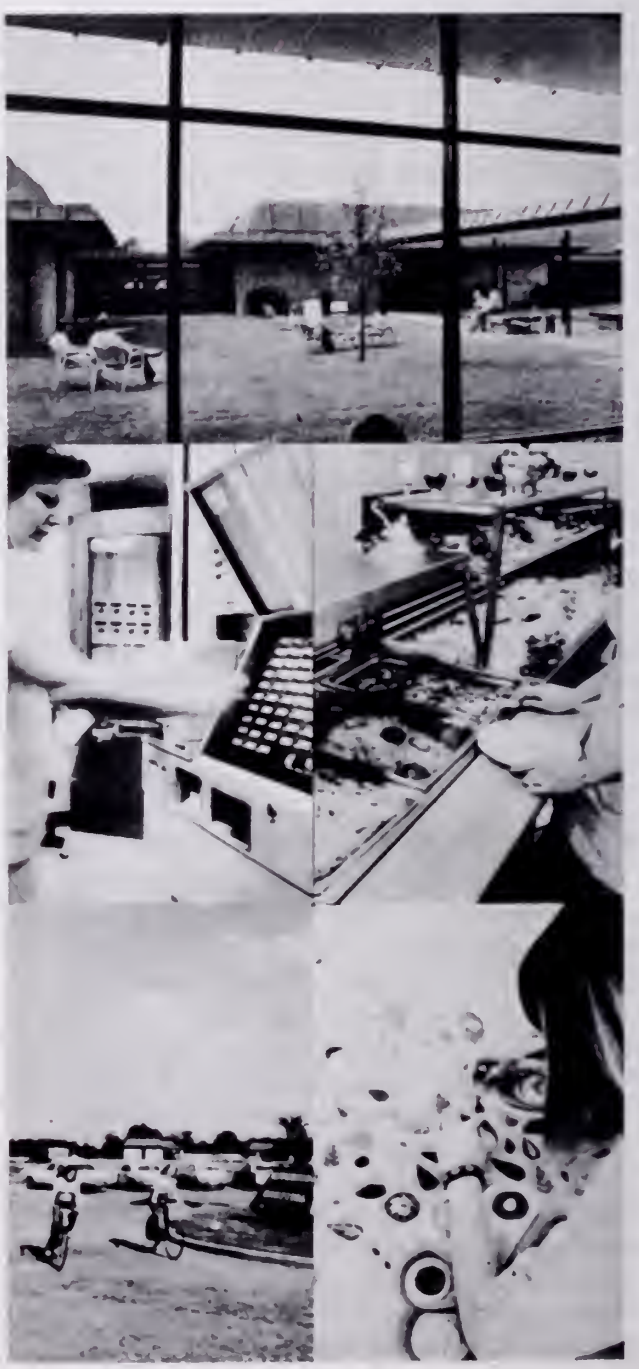
Architecturally designed to create an attractive open environment, Riverside's "non-institutional" atmosphere helps prepare the patient for specific therapy, healthy entertainment and physical recreation.

The clinical program incorporates a wide range of modern psychiatric ideas. Emphasis is placed on interpersonal relationships, small group functions, and professional individualized care.

The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

For additional information contact: John R. Reedy, Executive Director.



Riverside Hospital

P.O. Box 4297, Jackson, MS 39216
Telephone: (601) 939-9030

NEWSLETTER

August 1978

Dear Doctor:

AMA filed suit against the Federal Trade Commission in an effort to overturn the FTC's ruling on advertising of ophthalmologists' and optometrists' services. At issue is whether a federal administrative agency has the legal right to invalidate a law passed by a state legislature. FTC ruling prohibits states to have laws barring advertising of eyeglass prices and requires ophthalmologists and optometrists to give patients copies of their eye prescriptions.

> AMA joined as a co-plaintiff the Florida Medical Association lawsuit against HEW, seeking to stop government from publishing names of physicians who received Medicare payments last year. AMA was also granted a temporary restraining order in Chicago against HEW and Secretary Califano on the same issue.

The June 30 issue of the Federal Register announced that the economic index applicable to increases in the prevailing charges for physicians' services under Part B of Medicare for July 1, 1978, through June 30, 1979, is 1.426. This is an increase of 5.08 per cent over the economic index used for the previous 12 months.

Sen. Richard Schweiker recently introduced legislation to ensure that PSROs will not be subject to the full range of information disclosure requirements outlined in the Freedom of Information Act. Bill is necessary, he said, because of a D.C. court ruling that PSRO is an "agency" of the federal government for purposes of FOIA and is thus subject to its disclosure requirements.

Girl infants born this year can expect to live to be 81, and boys can expect to live to be almost 72, reports the U.S. Bureau of the Census, largely because of decline in cardiovascular death rates. Death rate of adults over 35 declined much more rapidly between 1973 and 1975 than it had during the previous 10 years. Median age of the U.S. population is 29, the agency said.

Hazards to infants from radiant warmers used in hospital delivery rooms and newborn care units was cited by American Academy of Pediatrics Committee on Environmental Hazards. Committee said heaters should be used "with caution and with consideration as to whether the benefits justify potential risk." Severe burns have been attributed to radiant warmer heating of plastic-lined disposable diapers.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

Chiropractic Services Are Viewed

Health Care Financing Administration chief Robert Derzon has urged the removal of chiropractic services from Medicare. Derzon stated that eliminating the present Medicare requirement that x-rays must show a "subluxation" of the spine prior to chiropractic treatment would save $24 million a year and removing chiropractic treatment would save another $30 million.

Derzon's recommendation was contained in remarks before the House Ways and Means Health Subcommittee on June 19 and 22. On July 4 an organization known as the "Medical Anti-trust Relief for Chiropractic and Humanity, an Indispensible New Cause-for-Action" announced that "over 3,000 chiropractors and their patients delivered a certification of over 300,000 names and addresses of people, collected during the month of June, to President Carter, Congress and HEW Secretary Joseph Califano supporting a petition calling for chiropractic patients to have equal rights in all federal health programs for their choice of both doctor and health care."

New Orleans Hospital Called White Elephant

The F. Edward Hebert Naval Regional Medical Center in New Orleans is a $22 million white elephant that should be abandoned by the Navy, reports the General Accounting Office. The Defense Department agrees with the findings.

The GAO, Congress' investigative agency, said the westbank installation has a daily average patient load of 23, less than 10 per cent of the 250-bed capacity. The potential for increasing the work load significantly "is virtually nonexistent," said GAO.

No blame was assessed by the GAO in its findings on the new installation that was dedicated in 1976 to Rep. F. Edward Hebert (D-La.), former chairman of the House Armed Services Committee.

Annual operating and payroll costs for the hospital amount to more than $7 million. GAO suggested the facility be used by the state of Louisiana for a planned adolescent mental health care installation, or that it be leased to Westbank Medical Center, Limited, which operates a nearby for-profit hospital.



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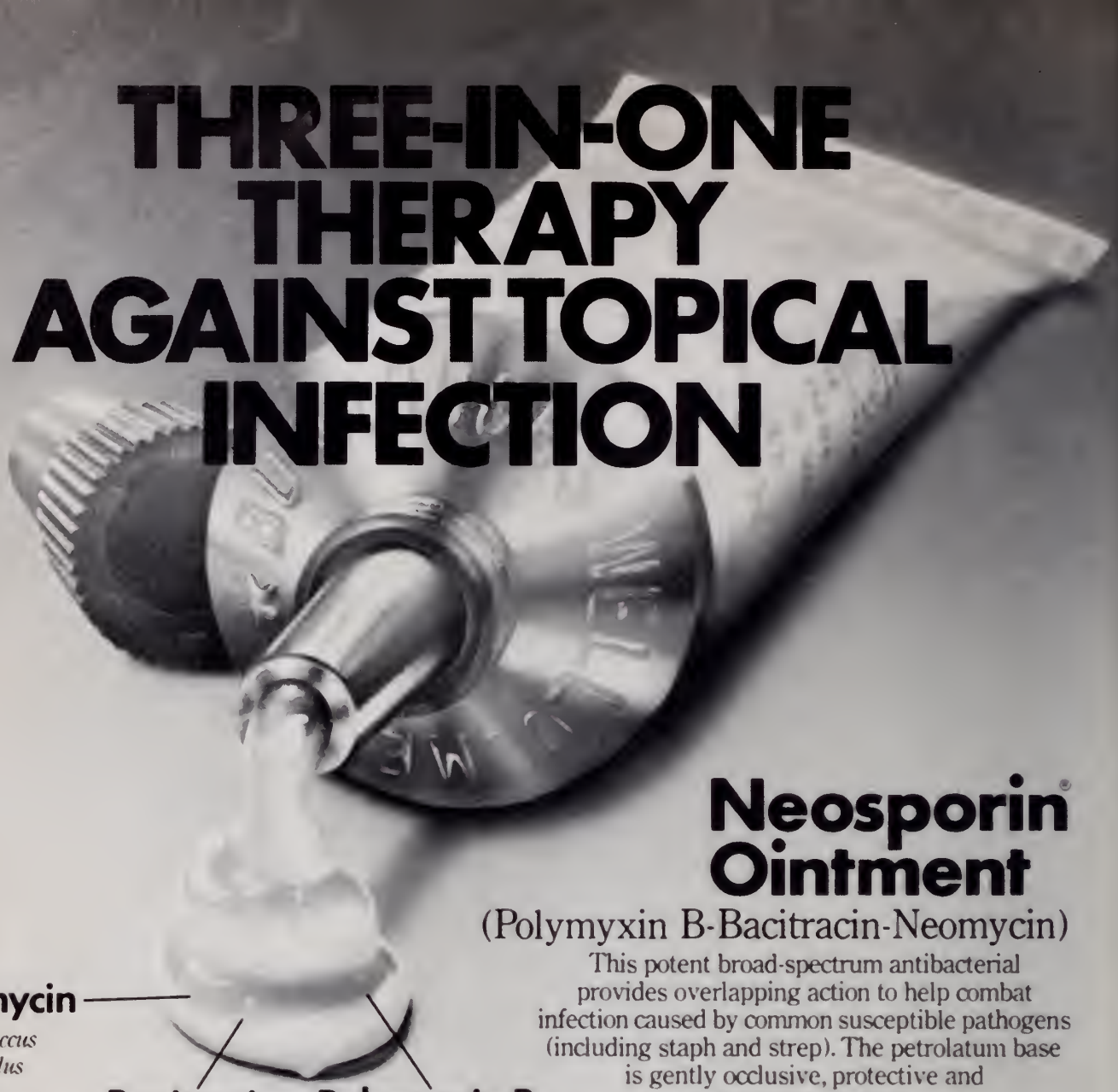
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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching, it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Clinical Labs Bill Is Approved

The House Ways and Means Health Subcommittee has approved the Clinical Laboratory Improvement Act.

The new provision would prohibit percentage contracts with hospital-based physicians unless the charges were "reasonable" in terms of what the hospital would have paid for such services if the physician had been employed by the hospital, and the cost of other "reasonable expenses" incurred by physicians in performing the services. This provision would be applicable to clinical laboratories outside of a hospital.

The Health Subcommittee also approved language which provides that "if the Joint Commission on Accreditation of Hospitals imposes standards for hospital laboratories that are at least equivalent to the national standards, the Secretary of HEW (or the state, in the case of a state with primary enforcement responsibility) could deem a laboratory in a JCAH-accredited hospital to be in compliance with the national lab standards."

The CLIA bill extending federal regulations over clinical labs has passed the Senate and the House Commerce Committee which sent it to Ways and Means. All the bills are similar. The physician office exemption in the Senate was not mandatory. The House exemption is automatic for groups of five or fewer, or for any size group if tests are done by the physicians themselves.

HEW's Health Centers Get Poor Marks

The nation's 112 neighborhood health centers have been cited as being overstaffed and underutilized by the General Accounting Office in a recent report to Congress.

The neighborhood health centers, which have been funded through HEW in Mississippi and other states, primarily serve the poor and receive most of the $197 million appropriated annually for community health center programs.

The centers are authorized to provide primary care including physician, laboratory, x-ray, preventive health and dental and transportation services as well as health education. About 1.4 million people are registered at the centers.

The GAO report states that the centers employ "more physicians, dentists and support personnel than are needed by the number of people using them." More than $1 million a year was being spent on unnecessary personnel at the six centers reviewed by GAO.

Adding to the problem of overstaffing is the "less than anticipated demand for services, due partly to the availability of other forms of health services such as hospital outpatient department," the report continues and also cites "traditionally high rates of broken appointments" in the centers as well as weak organization and management as further problems.

Dr. Guyton Lectures In London

Dr. Arthur Guyton, professor of physiology and biophysics and chairman of the department at the University of Mississippi Medical Center, delivered the Harvey Lecture in London July 13.

The Royal College of Physicians symposium commemorated the 400th anniversary of William Harvey's birth.

Dr. Guyton's lecture concluded five days of scientific presentations by international speakers. His topic was "Essential Cardiovascular Regulation—The Control Linkages Between Bodily Needs and Circulatory Function."

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DATELINE

Louisiana Establishes Fraud Control Unit

Baton Rouge, LA - On March 29 Louisiana became the first state to establish a fraud control unit under federal contract. The state will receive 90 per cent matching funds to hire a staff of 24 investigators, prosecutors, medical consultants, auditors and administrative personnel. Unit is authorized under PL 94-142, Medicare-Medicaid Anti-Fraud and Abuse Amendments to investigate possible criminal activities as well as to correct errors in overpayments and other routine procedures.

Radiation Scare Is Harmful to Patients

Austin, TX - Edward Teller, Ph.D., hydrogen bomb developer, said a radiation scare is causing more harm to patients than dangers from radiation itself. Speaking at the Texas Medical Association annual session, he stressed that fears of cancer from important medical uses of radiation in diagnosis such as mammography and in therapy have led many patients needlessly to reject such procedures and some physicians to be leary of suggesting them.

Womb Cancer Screening Device Aids Detection

Boston, MA - A new device from the Kendall Company which makes possible screening of all women at high risk for cancer of the lining of the womb could be a great step forward in identifying such cancers early enough to treat them more successfully. The CURITY Isaacs Endometrial Cell Sampler is a syringe-like instrument which draws cells from the lining of the womb for laboratory examination and study, not normally possible using the cervical or Pap smear test.

Hypertension Diet Cookbook Is Published

Bloomfield, NJ - A comprehensive and practical dietary guide for the estimated 35 million Americans who suffer from hypertension has been published by the HLS Press, Inc. Living with High Blood Pressure--The Hypertension Diet Cookbook offers hundreds of tested recipes to help hypertensives follow the diet, restricted in sodium, cholesterol, saturated fats and calories. Send $12.95 to HLS Press, 1455 Broad Street, Bloomfield, NJ 07003.

Watch for Study on Chymopapain

Chicago, IL - Physicians' attention is called to an in-depth study of chymopapain in the Medical News Section of the Journal of the American Medical Association of July 21. Chymopapain is the controversial drug that has been used to dissolve spinal discs. It is not licensed in the U.S., but is in general use in Canada and in Europe. The article is a case study in federal drug regulation and should be of interest to many physicians.

Califano Wants Consumer Boards

Consumers will have to comprise a majority of the boards of any insurance company serving as a fiscal intermediary for Medicare and Medicaid claims if a proposal by HEW Secretary Joseph Califano becomes effective, as expected.

Stating that the boards of such fiscal intermediaries make decisions that affect "how more than $25 billion in Medicare and Medicaid funds will be spent" Califano said "those who have a financial interest in the outcome of these decisions should not have the power (majority) to make them."

The requirement will change the makeup of some 20 of 32 Blue Shield Plans and 12 of 67 Blue Cross Plans. In Mississippi, which has a combined plan, the board of the plan was composed of a majority of public (consumer) members beginning this year.

Califano apparently rejected the advice of his own General Counsel and Health Care Financing Administration in issuing the proposal. An internal HEW memo from them noted that "although legally supportable, it is premature to adopt limitations on physician participation on the boards of Blue Shield organizations . . . for one thing, a preliminary analysis of available Medicare data by HCFA staff does not demonstrate any direct relationship between the degree of physician participation on Blue Shield boards and physicians fees . . ."

Parenthetically it might be noted that in Mississippi if any "undue" physician influence has been exerted on Blue Cross-Blue Shield it certainly hasn't had any effect on physicians' fees which are now among the lowest in the nation.

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UMC Administrative Changes Are Announced

Dr. J. Lincoln Arceneaux, associate professor of microbiology at the University of Mississippi Medical Center, has been named assistant dean for student affairs in the School of Medicine.

Dr. Norman C. Nelson, UMC vice chancellor and medical school dean, announced his July 1 appointment and changes in administrative responsibility for the school's two associate deans following approval of the Board of Trustees, Institutions of Higher Learning.

Dr. Carl Evers, associate dean for student affairs since 1973, has been designated associate dean for academic affairs, Dr. Nelson said. Dr. Richard Miller, a school associate dean since 1974, is now associate dean for clinical affairs.

Dr. Arceneaux joined the UMC faculty in 1970. A native of Lafayette, LA, he earned the B.S. degree at the University of Southwestern Louisiana in 1963, and the Ph.D. degree at the University of Texas at Austin in 1968. He was a National Institute of Health postdoctoral fellow at Princeton from 1967-1970.

Dr. Evers, professor of pathology, is a native of Lake Benton, MN. A B.A. graduate of Mankato State College, he earned the M.D. at the University of Minnesota in 1959. Dr. Evers took postgraduate training at UMC and joined the faculty in 1964 as an instructor in pathology. He is currently serving as president of MSMA.

Dr. Miller is a professor of surgery (pediatrics), assistant professor of pediatrics and University Hospital medical director. A Hartford, CT, native, Dr. Miller earned his undergraduate and medical degrees at Harvard University. He took postgraduate training at University Hospital in Cleveland, OH, prior to a year as a fellow in pediatric surgery at Royal Children's Hospital in Australia. He was chief of pediatric surgery at Cleveland's Metropolitan General Hospital from 1967-1969. He came to UMC from Cleveland in 1969.

MEETINGS

National and Regional

American Medical Association, House of Delegates interim session, Chicago, Dec. 2-6, 1978. James H. Sammons, Executive Vice President, 535 N. Dearborn St., Chicago, IL 60610.

Louisiana-Mississippi Ophthalmological & Otolaryngological Society, April 19-20, 1979, Broadwater Beach Hotel, Biloxi, MS. Ben A. Davis, Jr., CAE, Executive Secretary, P.O. Box 12314, Jackson, MS 39211, telephone (601) 956-7787.

The New Orleans Graduate Medical Assembly, "Management of Common Problems in Office Practice—Update"; April 27-May 1, 1979, The Fairmont, New Orleans, LA. Lois Neary, Executive Director, 1430 Tulane Avenue, New Orleans, LA 70112.

State and Local

Mississippi Academy of Family Physicians, Annual Meeting, July 11-14 1979, Biloxi. Mrs. Alyce Palmore, Executive Secy., P.O. Box 12330, Jackson 39211.

Mississippi State Medical Association, 111th Annual Session, May 7-10, 1979, Biloxi. Charles L. Mathews, Executive Secy., 735 Riverside Drive, P.O. Box 5229, Jackson 39216.

Amite-Wilkinson Counties Medical Society, 3rd Monday, March, June, September, December. James S. Poole, Secy., The Gloster Clinic, Gloster 39638. Counties: Amite, Wilkinson.

Central Medical Society, 1st Tuesday, January, April, September, November, 6:30 p.m., Primos Northgate Restaurant, Jackson. Patsy Douglas, Executive Secy., B6 Medical Arts Bldg., 1151 N. State St., Jackson 39201. Counties: Hinds, Leake, Madison, Rankin, Scott, Simpson, Yazoo.

Claiborne County Medical Society, 1st Tuesday each month, 6:00 p.m., Claiborne County Hospital, Port Gibson. D. M. Segrest, Secy., P.O. Box 147, Port Gibson 39150. County: Claiborne.

Clarksdale and Six Counties Medical Society, 3rd Wednesday, April, and 1st Wednesday, November, 2:00 p.m., Clarksdale. Henry McCrory, Secy., P.O. Box 340, Clarksdale 38614. Counties: Coahoma, Quitman, Tallahatchie, Tunica.

Coast Counties Medical Society, 1st Wednesday, January, March, May, September and November. H. S. Barrett, Secy., P.O. Box 1898, Gulfport 39501. Counties: Hancock, Harrison, Stone.

Delta Medical Society, 2nd Wednesday, April and October. Walter H. Rose, Secy., 122 E. Baker St., Indianola 38751. Counties: Bolivar, Humphreys, Leflore, Sunflower, Washington.

DeSoto County Medical Society, 3rd Thursday, February and August, 1:00 p.m., Kenny's Restaurant, Hernando. Malcolm D. Baxter, Jr., Secy., Baxter Clinic, Hernando 38632. County: DeSoto.

East Mississippi Medical Society, 1st Tuesday, February, April, June, October, December. G. L. Arrington, Jr., Secy., P.O. Box 4128 West Station, Meridian 39301. Counties: Clarke, Kemper, Lauderdale, Neshoba, Newton, Winston.

Homochitto Valley Medical Society, 1st Tuesday, February, June, September, December, Ramada Inn, Natchez. Walter T. Colbert, Secy., P.O. Box 1167, Natchez 39120. Counties: Adams, Jefferson.

North Central District Medical Society, 3rd Wednesday, March, June, September, December. Bernard Hunt, Secy., 1196 Mound St., Grenada 38901. Counties: Attala, Carroll, Choctaw, Grenada, Holmes, Montgomery, Webster.

Northeast Mississippi Medical Society, 1st Thursday, March, June, September, December. James M. Cooper, Secy., 605 Garfield St., Tupelo 38801. Counties: Alcorn, Calhoun, Chickasaw, Itawamba, Lee, Monroe, Pontotoc, Prentiss, Tishomingo, Union.

North Mississippi Medical Society, 1st Thursday, April, October. Cherie Friedman, Secy., 424 South 5th, Oxford 38655. Counties: Benton, Lafayette, Marshall, Panola, Tate, Tippah, Yalobusha.

Pearl River County Medical Society, 2nd Monday, March, June, September, December. J. C. Griffing, Secy., Crosby Memorial Hospital, Picayune 39466. County: Pearl River.

Prairie Medical Society, 2nd Tuesday, March, June, September, December. George Walker, Secy., 102 W. Lampkin St., Starkville 39759. Counties: Clay, Oktibbeha, Lowndes, Noxubee.

Singing River Medical Society, 3rd Monday, February, May, August, November. D. W. Lamppin, Secy., P.O. Drawer J, Pascagoula 39567. County: Jackson.

South Central Mississippi Medical Society, 2nd Tuesday, March, June, September, December. Julian T. Janes, Secy., 304 Clark, McComb 39648. Counties: Copiah, Franklin, Lawrence, Lincoln, Pike, Walthall.

South Mississippi Medical Society, 2nd Thursday, March, June, September, December. Clyde Allen, Secy., 1245 N. 6th Ave., Laurel 39440. Counties: Covington, Forrest, George, Greene, Jasper, Jefferson Davis, Jones, Lamar, Marion, Perry, Smith, Wayne.

West Mississippi Medical Society, 2nd Tuesday, January, March, May, September, October, November, 6:30 p.m., Magnolia Motor Motel, Vicksburg. Martin E. Hinman, Secy., The Street Clinic, Vicksburg 39180. Counties: Issaquena, Sharkey, Warren.

New Student Aid Fund Is Established



The Medical Student Wives Auxiliary at the University of Mississippi Medical Center has established a new financial aid fund for medical students. A $1,000 gift from the auxiliary provides a base for the low interest, short-term emergency loan fund. Mrs. Alfred G. Windham, center, whose husband is a senior medical student, is auxiliary president. With Mrs. Windham are Dr. Norman C. Nelson, left, UMC vice chancellor and School of Medicine dean, and Bob Blacklock, UMC student body president.

Counsel to Authors

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All copy must be double spaced, including legends, footnotes, and references. Generous margins at the top, bottom, and on both sides of the page should be allowed. Each page after the title page should be consecutively numbered and carry a running head identifying the paper and author.

Titles should be short, specific, and clear. Ordinarily, a title should not exceed 80 characters, including punctuation.

References should be limited to a maximum of 10. If there are more than 10, the references will be omitted and a notation made to write the author for a complete list. Textbooks, personal communications, and unpublished data may not be cited as references. References must include names of authors, complete title cited, name of journal or book spelled out or abbreviated according to the *Index Medicus,* volume number, first and last page numbers, month, date (if published more frequently than monthly), and year. References should be arranged according to order listed in the text and must be numbered consecutively.

Manuscripts accepted for publication are subject to copy editing. Authors will receive galley proof prior to publication. Galley proof is only for correction of errors, and text changes may not be made. The galley proof should be returned by the author within 48 hours from receipt, and no further changes may be made.

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Medical Center Adds to Faculty

Eight new faculty members have joined the School of Medicine and centerwide faculties at the University of Mississippi Medical Center.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced the appointments following approval by the Board of Trustees, Institutions of Higher Learning.

The new medical school faculty members are Dr. Edward G. Long, associate professor of psychiatry; Dr. William Clyde Nicholas, associate professor of medicine; Dr. Debesh Chandra Mazumdar, Dr. Spencer Louis Schreiter and Dr. Ralph Brooks Vance, assistant professors of medicine; Dr. Stephen Hamilton Hindman, instructor in medicine; and Karen Lynn Morere, instructor in surgery (otolaryngology). Dr. Sridhara Sridhara is centerwide associate professor of biochemistry.

Dr. Long joins the faculty Sept. 1. He has been associate clinical professor of psychiatry at the Colorado School of Medicine in Denver since 1977. He was a lecturer and supervisor at Northwest Denver Mental Health Center from 1972-1977. Formerly in private practice in Louisiana, Dr. Long received the B.S. degree at Louisiana State University in 1951. He earned the M.D. at the LSU School of Medicine in 1955, and interned at Gorgas Hospital in the Panama Canal Zone. He took residency training at Charity Hospital in New Orleans.

Dr. Nicholas, who joins the UMC faculty in August, has been associate professor of medicine at Dalhousie University Medical Center in Halifax, Nova Scotia, since 1972. He was assistant professor of medicine at McMaster University Medical Center in Hamilton, Ontario, from 1964-1971. A 1958 M.D. graduate of Dalhousie, Dr. Nicholas took postgraduate training at St. John's Hospital in Newfoundland, Sunnybrooke Hospital and Toronto General Hospital in Toronto, Victoria General Hospital in Halifax and Middlesex Hospital in London.

Assistant professor of medicine at Washington University Medical Center in St. Louis since 1973, Dr. Mazumdar earned the M.B.B.S. degree at the All Indian Institute of Medical Sciences in New Delhi in 1964. Dr. Mazumdar interned and was on the house staff there until 1966. He took residency training at the University of Mississippi Medical Center, and held fellowships at UMC and at Washington University Medical Center. He joined the UMC faculty in July.

Dr. Schreiter, who also joined the faculty last month, received the B.A. degree from the University of Mississippi in 1962. He earned the M.D. degree and took postgraduate training at the Mississippi Medical Center. An Air Force veteran, he has been a fellow at UMC since 1976.

Dr. Vance is a 1967 B.A. graduate of Ole Miss. He earned the M.D. degree and took postgraduate training at UMC. A UMC fellow since 1975, he joined the faculty in July.

A UMC resident since 1977, Dr. Hindman earned the B.A. degree at Ole Miss in 1969. He earned his M.D. degree at the UMC School of Medicine in 1973. After interning at H. C. Moffitt Hospital in San Francisco from 1973-1974, Dr. Hindman was an epidemiology intelligence service officer for the Center for Disease Control in Phoenix, 1974-77.

Speech pathologist with the New Orleans Speech and Hearing Center since 1974, Ms. Morere is a B.A. graduate of Southeastern Louisiana University. She received the master of communicative disorders at the University of Mississippi in 1973 and was an instructor and speech pathologist at UMC the following year. She returned to UMC in July.

An American Heart Association established investigator since 1973, Dr. Sridhara comes to UMC from Evanston, IL. He earned the B.S. and M.S. degrees at the University of Mysore in India.

THE MAGAZINE COLLECTOR



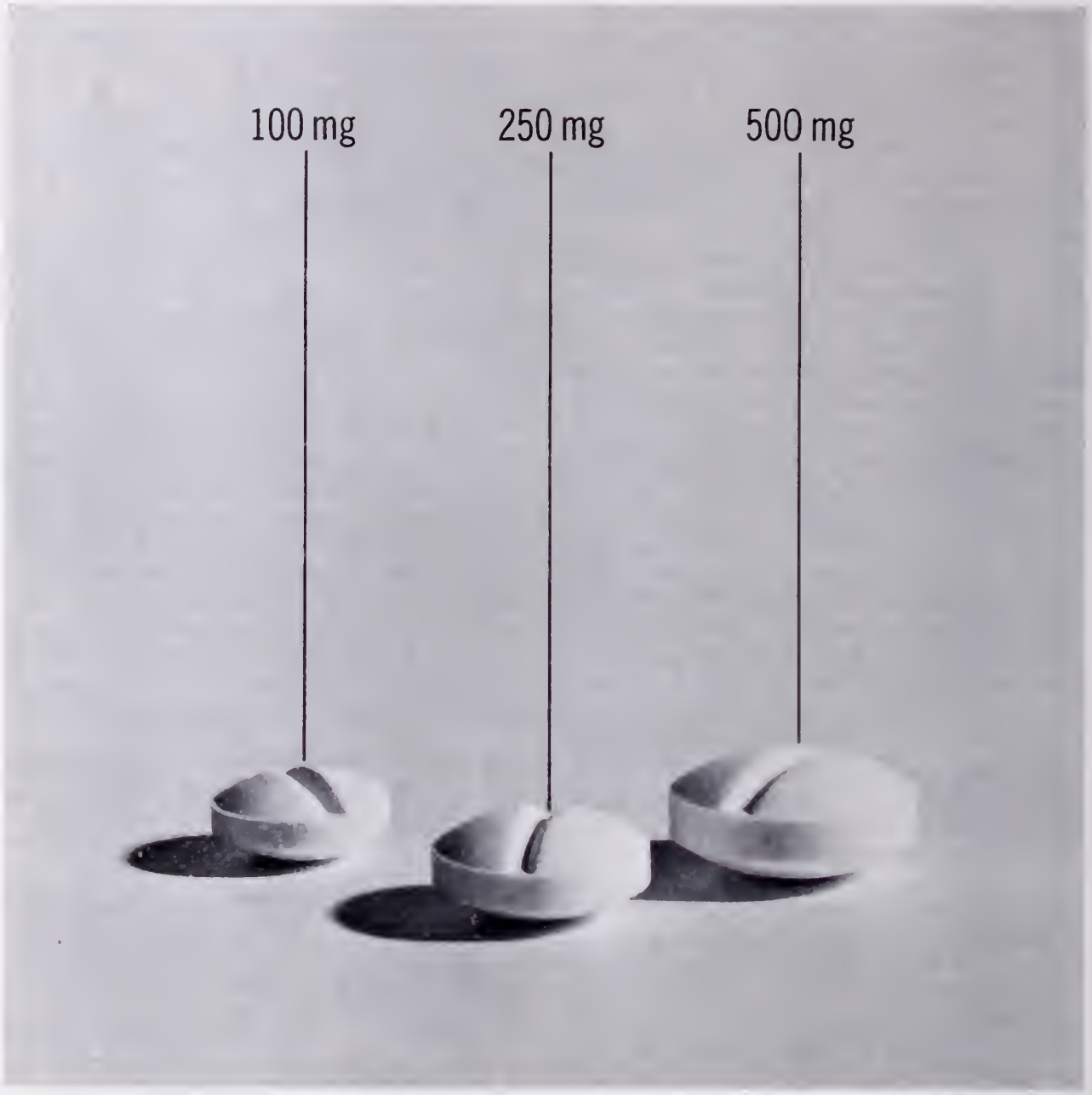
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ORIGINAL PAPERS

Emergency Treatment of Shock—Use of Medical Antishock Trousers (MAST)

ROBERT R. LOWE, JR., M.D.
Jackson, Mississippi

THE LEADING CAUSE of death in ages 1-40 is trauma.[1] A close look at many of these circumstances of trauma shows that not all of the victims received irreversible organ damage (assuming modern methods of stabilization, early resuscitation and transport could have been available). Along with airway problems, death in many cases is secondary to uncontrolled hemorrhage and shock. First aid measures presently available to all rescue personnel include:

1) Maintenance of an adequate airway and artificial ventilation when indicated

2) Control of external hemorrhage as much as possible

3) Administration of oxygen

4) Prevention of heat loss by blankets, etc.

5) Splinting of fractures

6) Elevation of lower extremities to allow some of the pooled blood available to central circulation (not possible if fractures are present in legs or pelvis).

All of the above procedures can be useful in managing a patient in shock but if definitive therapy (e.g. surgery) is delayed, significant mortalities can be expected. Certainly a more definitive prehospital and emergency department modality is needed.

The time-honored mainstay of intravenous administration of crystalloids and colloids early, followed by blood as soon as available and surgery (if necessary) has been one of the primary reasons for recently increased survival rates. Experience in the military has shown unequivocally that early fluid resuscitation coupled with rapid, safe evacuation can save lives previously lost to shock. More recently this experience has been expanded to include the civilian population utilizing paramedics trained in IV techniques.

A leading cause of death is trauma attributable in many cases to uncontrolled hemorrhage and shock. Medical Antishock Trousers (MAST), a simple externally applied device, can provide a rapid means to autotransfusion in patients with certain forms of traumatic shock. The author, an emergency room physician, describes the trousers, procedures for their use and gives two illustrative cases.

Rapid, vigorous replacement of crystalloids (e.g. Ringer's lactate) remains our most important means of combating shock early. Unfortunately adequate aggressive volume replacement is not always possible.

1) Profoundly hypotensive patients at accident sites or in emergency departments can present a challenge to even the most adept intravenous cannulator (especially when dealing with pediatric patients).

2) Total volume of infused crystalloid doesn't remain in the intravascular space (up to 60 per cent of rapidly administered Ringer's lactate may leak into the perivascular space).

3) Even with multiple large bore catheters, it may take 15-60 minutes to infuse 1000 cc.

From the Emergency Department, Hinds General Hospital, Jackson, MS.

Application of a principle first envisioned by Crile in 1900[2] of an inflatable pneumatic suit for autotransfusion of one's own sequestered venous and capillary blood in the legs and abdomen has recently been reexamined. Crile's principle was originally utilized in the aviation industry (G-suit) to prevent pilot blackout during sharp or steep dives. Culter and Daggett[3] as early as 1969 realized the potential for the use of a modified G-suit for the management of hemorrhagic shock. In 1973 Kaplan[4] and others after extensive military trials developed an inflatable trousers suitable for emergency use.

Up to 60 per cent[5] of the total blood volume is located in the venous circulation (much of this is in lower extremities, pelvis and abdomen) and some of this is pooled and unavailable during periods of hypoperfusion. If one could rapidly, in a non-invasive way, mobilize this sequestered blood into the central circulation, beneficial effects might be obtained. This would be similar in principle but more effective than elevation of the legs.

1) A circumferential pneumatic device encompassing the lower extremities and abdomen could immediately autotransfuse up to an estimated 1000 cc[6] of warm, autologous, normally clotting blood.

2) Pelvic and lower extremity fractures could be splinted as with an air splint (present air splints are not effective in autotransfusion).

3) Some degree of control of external hemorrhage under such a suit.

4) Potential help in tamponading hemorrhage from pelvic and intraabdominal sources.[7]

5) Mobilization of blood to central circulation could help fill collapsed veins of the upper body making IV's easier to start.

6) Minimizing the severity and duration of shock could conceivably reduce the incidence of acute organ failure (e.g. acute tubular necrosis, post-traumatic pulmonary insufficiency)

7) Abdominal surgery can occur with legs still inflated if necessary.

A pneumatic suit, MAST® trousers (originally Military Antishock Trousers—David Clark Co.), is now available for all prehospital and emergency personnel. The unit presently recommended (MAST III) is a three-chambered, double-layered polyurethane coated nylon fabric with Velero® fasteners. It is almost universally applicable (with the pediatric model useful in patients weighing less than 50 pounds. Both adult and pediatric models are adjustable with the Velero® fastener. When properly applied and inflated with a foot pump it is capable of maintaining an internal unit air pressure of 104 mm mercury (i.e. pressure within the suit—not necessarily the patient's pressure). Safety pop-off valves and Velero® construction prevent over-inflation and negate the need for pressure gauges.

Procedure for Application (see Figure 1):

1) Maintain airway, breathing and circulation as first priority as in any situation.

2) Rapidly evaluate patients' status and vital signs. If shock is present, apply MAST.

a) Relative indication in adults with signs of shock and pressure less than 100 mm mercury systolic.

b) absolute indication if pressure less than 80 mm mercury with associated signs and symptoms.

3) Placement and inflation.

a) Either place patient supine on open suit or place suit under patient. Have pump attached to all three compartments and ready for inflation with stopcocks open.

b) Wrap left leg first, then right leg, then abdomen snugly just *below* lower costal margins. (Caution-enclosing lower chest could impede ventilation)

c) Pump until Velero® fasteners slip or "crackle" or safety valves open—inflate legs first then abdomen.

d) Close all valves and remove tubing and pump. (see Figure 2)

e) Carefully monitor vital signs.

f) Never deflate in the field except to further control local hemorrhage and then rapidly reinflate the involved compartment.



Figure 1. MAST suit ready for application with attached inflation tubing and foot pump.

Two trained rescuers can accomplish the above procedure in 60 seconds with immediate autotransfusion, hemorrhage controlled and involved fractures splinted all in one maneuver. Improvement in

vital signs can be either immediate or within a few minutes.



Figure 2. Fully inflated suit applied and tubing removed. Patient is ready for transport or continuing therapy. Caution not to encompass the chest.

Although the MAST suit represents a major advance in the early treatment of shock there are some potential and real cautions:

1) Untrained personnel may want to remove trousers for

a) X-rays
b) EKG
c) Urinary catheterization
d) To inspect entire patient

EKG leads may be placed and Foley inserted with suit fully inflated and radiographs are possible through the suit. If patient is to be examined, deflate only one area at a time.

2) Improper placement enclosing the lower thorax can impede breathing.

3) Urination, defecation or emesis might be stimulated by the suit pressure. This has not been a clinical problem.[7]

4) Pressure for prolonged periods could produce impairment of function of the legs and the development of tissue acidosis which would be released into the general circulation on deflation. This is not usually a significant problem but some recommended administration of 1-2 ampules of bicarbonate (44-88 mEq) after full deflation.

5) Use of the suit is contraindicated in pulmonary edema.

6) Early fears arose concerning use in shock associated with injuries above the level of the trousers as the increased perfusion could increase hemorrhage. This has not been proven to be a major consideration[7] (the increase in cerebral perfusion would outweigh the possibility of overtransfusion and cerebral edema).

It seems that almost all documented problems with MAST have not been in the application but in the improper deflation of the unit. Obviously any blood shunted to the central circulation will immediately revert back to its sequestered position upon rapid deflation prior to adequate volume replacement.

Procedure for Deflation

The procedure for deflation is as follows:

1) Check vital signs.

2) Disconnect inflation tubing (if not already done) and gradually deflate abdominal compartment *first* (if the abdominal unit were left inflated with the legs deflated it could act as a tourniquet impeding venous return from legs). At each 5 mm mercury drop in blood pressure discontinue deflation until further volume replacement has occurred (CVP or Swans-Ganz catheter is useful in monitoring some situations).

3) Deflate each leg separately following the same procedure as with the abdomen.

4) Consideration should be given to administration of 1-2 ampules of bicarbonate[8] if the suit has been on for prolonged periods. It is best to monitor arterial pH if further bicarbonate is to be administered. The total time for deflation may be from 20-30 minutes and frequently should be delayed only until blood or definitive surgery is in readiness. Deterioration of vital signs on deflation is an indication for further volume replacement.

The following case reports are examples of early use of MAST at Hinds General Emergency Room.

Case No. 1

A 47-year-old black male was brought to Hinds General Hospital via automobile following a point-blank shotgun blast to the left lower leg and foot. Significant delay in transportation was suspected. On arrival the patient was incoherent, cold, clammy and in spite of a tight make-shift bandage was sustaining brisk hemorrhage; airway and breathing were adequate. Initial vital signs were: pulse 140 and thready, BP 80/50. Direct control of bleeding was difficult due to massive bone and soft tissue damage. Bulky dressings were applied and the MAST suit immediately inflated while IV's were being started and appropriate blood work drawn. Blood pressure immediately on inflation was 98/70 and the patient's sensorium improved. Five minutes later with two large bore IV's going (approximately 300-500 cc Ringers infused) BP was 110/80 and pulse 110. By now tetanus and antibiotic prophylaxis had been given, nasogastric tube and Foley catheter inserted and EKG, chest and extremity x-rays obtained with

the suit in place. As blood pressure continued to improve, the pressure of the suit was less effective in controlling the bleeding. On arrival of the orthopedic surgeon the involved leg was reinspected. Brisk bleeding occurred and pressure immediately fell to 70/50 on deflation of the single leg. Dressings were reapplied, leg compartment reinflated and fluid replacement accelerated with return of BP to previous levels. Whole blood was administered prior to and during surgery. The patient had a stormy course with his leg but no pulmonary or renal complications were encountered.

Case No. 2

A 72-year-old white male awoke with severe steady lower abdominal pain and fainted at home. He had one episode of vomiting on awakening. There was no chest pain or dyspnea or known previous heart disease. The patient was communicative while enroute to the hospital, but immediately on reaching the Emergency Room had a "cardiac arrest." Immediate monitoring disclosed sinus bradycardia of 30. Cardiopulmonary resuscitation was instituted. Atropine was given intravenously and Isuprel begun. The rate increased to 80 but blood pressure was still not measurable. Femoral and carotid pulses were weakly palpable. Levophed was begun pending further evaluation. The patient's blood pressure was 60/20 shortly afterwards. The hemoglobin came back at 10.8 gm. The possibility of a ruptured abdominal aneurysm was entertained so the MAST was applied. Blood pressure immediately rose to 70/50 and within 3 minutes was 90/60. The patient was making feeble respiratory efforts. With this response another large bore peripheral IV and an internal jugular line were started and fluids speeded up. Type specific blood was administered and a surgeon was consulted. While awaiting surgery the CVP was checked and found to be 18 cm H_2O. The abdominal compartment of the MAST suit was deflated but the blood pressure fell to 60/40 so reinflation was done with return of the blood pressure to previous levels. The patient went to surgery and was found to have a large ruptured abdominal aneurysm. He probably sustained an infarct and did not survive.

The use of the MAST suit is not being advocated as absolutely necessary in every hypotensive patient. Its availability for use in indicated situations, however, does provide a rapid, inexpensive and safe adjunctive means of combating shock especially in the prehospital and emergency areas. Intravenous fluid administration remains a valuable modality but due to practical problems such as unavailability of trained personnel there are certain limitations. (Nurses in coastal Mississippi and paramedics in Hattiesburg are presently the only field personnel routinely giving fluids.) Primary use at present has been in managing hemorrhagic shock, but recent studies have researched its use in other areas (e.g. cardiogenic shock) where a readily reversible "volume challenges" for preload adjustment may be indicated. This merits further consideration.[8]

By spring or early summer trained rescue personnel will begin utilizing the MAST in the field. Their training will include a review on rapid diagnosis of shock along with the effective use of MAST. This is largely due to efforts by the Mississippi State Board of Health Office of Emergency Medical Services and the Mississippi Chapter of American College of Emergency Physicians (ACEP). The Governor's Office of Highway Safety has purchased approximately 30 units across the state allowing many areas involved in emergency cases to become familiar with this useful device.

Conclusion

Medical Antishock Trousers (MAST), a simple externally applied device, provides a rapid means of autotransfusion in patients with certain forms of traumatic shock. It may also have wider application in other forms of shock and deserves wider use. ★★★

1850 Chadwick Drive (39104)

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The Health Manpower Project

MARK LYNCH, MARTHA IRBY, MARY BRANTLEY and RON SENNETT
Jackson, Mississippi

FOR THE PAST three years, the Health Manpower Unit of the Mississippi State Board of Health (MSBH) has been collecting statistical data on physicians licensed in Mississippi. This year marks the fourth year of this successful project, yet most physicians never see the results of their efforts in completing our questionnaires. It is for this reason that we are attempting to initiate an annual program with this publication whereby the Health Manpower Unit of the MSBH will publish aggregate statistics on licensed physicians at the end of each license renewal period. Furthermore, many physicians are unaware of the purposes of the project and, in what follows, we will attempt to delineate the reasons for its emergence, and its importance to health care delivery in Mississippi.

In the past, there have been numerous independent surveys undertaken by various organizations which led to much duplication and repetition of statistical data, in addition to burdensome paperwork for health personnel. Discrepancies evolved due to differences in definitions, standards, and timing and analyses of the various statistics were, consequently, incongruous. In lieu of all this, it was evident that Mississippi, as well as the rest of the country, was in dire need of a more efficient statistical system which would yield uniform and unique data, necessary for efficacious analyses.

In July of 1975, the MSBH received contract number HRA-230-75-0161 from the National Center for Health Statistics (NCHS), an agency of the U. S. Public Health Service, to implement the Health Manpower Statistical System (HMSS). It is through this system that the MSBH is attempting to define Mississippi's health needs and alleviate the problems of statistical analysis which were manifest in previous, uncoordinated efforts. The HMSS represents a single source of statistical data for the various health professionals in the state. This solitary and vital source of information guarantees unique and uniform data through common definitions, standards, and methodologies. It is a means for continuous and periodic health manpower data collection which can supply accurate and current statistics on the numbers, characteristics, and distribution of Mississippi's health personnel to planners, schools, and licensing boards.

Health professionals presently participating in the project are doctors of medicine, chiropractors, doctors of osteopathy, registered nurses, licensed practical nurses, nursing home administrators, optometrists, pharmacists, physical therapists, and podiatrists. Our files are replete with statistical data on each of these professions and we are expecting to publish a booklet of combined health statistics encompassing each of these fields in the near future.

For the past three years, the Health Manpower Unit of the State Board of Health has been collecting statistical data on physicians licensed in Mississippi. This article contains aggregate statistics on licensed physicians in the state for the years 1975, 1976 and 1977.

However, the statistical information collected by this office is strictly confidential and no information will be published or released if an individual physician is identifiable unless this office receives written permission from the said individual to do so. Since such consent has never been obtained in the past, nor are there plans presently to do so in the future, no information will be released if an individual is identifiable. Federal laws are unequivocal on the matter of confidentiality and provide for penalties for violations. Section 308(d) of the Civil Service Act protects Health Manpower data by assuring that all information received from you can only be used for the purposes we state in obtaining it and that you agree to in providing it.

This office has made every effort to facilitate completion of the questionnaires by utilizing pre-printed computer forms. The physicians are requested to complete an initial questionnaire and all subsequent questionnaires are pre-printed by computer and contain the information they already supplied. All the physician is requested to do is verify the information on the form. This will substantially reduce their

From the Health Manpower Unit, Mississippi State Board of Health, Jackson, MS.

time in completing the form and our time in editing and processing the data. We hope the physicians in the state will continue to be as responsive to the questionnaires as in the past and ensure both the quantity and quality of health manpower statistics in the future.

The two tables are comparisons of the statistics gathered during the last three years. Three years of data collection can by no means depict trends for the future but the value of such collections will be manifest in years to come. And their value is dependent upon the cooperation of each and every physician in accurately completing the health manpower questionnaires. (Please see pp. 152-154.) ★★★

P.O. Box 1700 (39205)

TABLE 1

PHYSICIANS LICENSED BY THE MISSISSIPPI STATE BOARD OF HEALTH AS OF JULY 1, 1975, '76, '77

	Physicians in Mississippi			*Physicians Out of State*			*All Licensees*		
	'75	'76	'77	'75	'76	'77	'75	'76	'77
Status									
Active	2144	2281	2372	1849	1811	1879	3993	4092	4251
Inactive	57	58	75	39	67	37	96	125	112
Total	2201	2339	2447	1888	1878	1916	4089	4217	4363
Active only									
Race									
White	2047	2164	2229	1753	1707	1766	3800	3871	3995
Black	49	50	59	58	60	62	107	110	121
Indian	4	3	2	1	—	—	5	3	2
Asian	43	63	82	36	42	50	79	105	132
Other	1	1	—	1	2	1	2	3	1
Sex									
Male	2027	2147	2229	1772	1736	1793	3799	3883	4022
Female	117	134	143	77	75	86	194	209	229
Age									
Under 30	190	204	203	181	160	183	371	364	386
30-34	287	335	357	325	321	342	612	656	699
35-39	305	300	319	274	281	304	579	581	623
40-44	301	322	342	292	292	281	593	614	623
45-49	273	280	289	248	241	243	521	521	532
50-54	285	290	289	220	210	203	505	500	492
55-59	192	215	240	159	161	166	351	376	406
60-64	136	136	136	91	88	97	227	224	233
65-69	85	103	106	38	37	38	123	140	144
≥70	90	96	91	21	20	22	111	116	113
Patient Care Hours									
00	11	16	35	19	18	60	30	34	95
1-10	31	36	38	32	38	38	63	74	76
11-25	87	94	105	120	110	110	207	204	215
26-40	281	306	382	308	314	396	589	620	778
41-55	496	519	611	507	509	499	1003	1028	1110
56-70	701	743	825	509	501	522	1210	1244	1347
>70	329	396	315	217	228	217	546	624	532
Unknown	208	171	61	137	93	37	345	264	98
Total Hours									
1-10	10	14	13	4	1	5	14	15	18
11-25	19	29	34	10	11	15	29	40	49
26-40	145	158	260	144	146	203	289	304	463
41-55	395	459	655	465	480	606	860	939	1261
56-70	650	684	914	546	554	690	1196	1238	1604
>70	347	448	438	266	297	322	613	745	760
Unknown	578	489	58	414	322	38	992	811	96

TABLE 2

ACTIVE PHYSICIANS IN MISSISSIPPI—JULY 1, 1975, '76, '77—
FEDERAL AND NONFEDERAL PRIMARY CARE SPECIALTIES BY COUNTY*

County	*Family Practice*			*General Practice*			*Internal Medicine*			*Ob-Gyn*†			*Pediatrics*‡			*Others and Unknown*			*Total*		
	'75	'76	'77	'75	'76	'77	'75	'76	'77	'75	'76	'77	'75	'76	'77	'75	'76	'77	'75	'76	'77
Total	219	243	256	284	296	377	196	222	240	140	156	165	120	140	151	1185	1224	1183	2144	2281	2372
Adams	4	4	6	3	6	7	3	4	4	5	5	4	4	4	4	33	33	34	52	56	59
Alcorn	1	2	2	6	6	8	1	1	1	1	1	2	2	1	2	11	15	12	22	26	27
Amite	2	2	1	—	—	—	—	—	—	—	—	—	—	—	—	1	1	1	3	3	2
Attala	1	1	3	3	3	1	—	—	—	1	1	1	—	—	—	2	2	2	7	7	7
Benton	—	—	—	1	1	1	—	—	—	—	—	—	—	—	—	—	—	—	1	1	1
Bolivar	4	6	4	9	7	12	2	2	1	3	2	1	2	1	2	9	9	5	29	27	25
Calhoun	—	—	2	3	4	2	—	—	—	—	—	—	—	—	—	2	2	2	5	6	6
Carroll	1	1	—	2	2	3	—	—	—	—	—	—	—	—	—	—	—	—	3	3	3
Chickasaw	2	2	2	—	—	1	1	1	1	—	1	1	—	1	1	7	8	9	10	13	15
Choctaw	2	3	1	1	1	2	—	—	—	—	—	—	—	—	—	1	—	—	4	4	3
Claiborne	—	—	—	3	2	3	—	—	—	—	—	—	—	—	—	—	—	—	3	2	3
Clarke	1	1	2	3	3	3	—	—	—	—	—	—	—	—	—	—	—	—	4	4	5
Clay	1	1	1	3	3	5	—	—	—	—	1	—	1	1	1	3	3	2	8	9	9
Coahoma	3	3	3	3	2	2	4	3	3	5	5	5	1	1	1	11	14	17	27	28	31
Copiah	7	7	7	2	2	4	—	—	—	—	—	—	—	—	—	3	2	1	12	11	12
Covington	4	4	4	—	—	1	—	—	—	—	—	—	—	—	—	1	2	1	5	6	6
Desoto	1	1	3	5	4	3	—	—	—	—	—	—	—	—	—	3	4	1	9	9	7
Forrest	4	4	6	7	7	7	6	7	6	5	6	6	6	7	7	67	68	77	95	99	109
Franklin	1	1	1	1	2	3	—	—	—	—	—	—	—	—	—	2	2	—	4	5	4
George	2	2	2	2	4	4	—	—	—	—	—	—	—	—	—	2	1	1	6	7	7
Greene	—	—	—	2	1	1	—	—	—	—	—	—	—	—	—	1	1	1	3	2	2
Grenada	3	3	3	—	—	—	1	1	2	1	—	2	—	—	2	12	14	13	17	18	22
Hancock	2	2	2	2	1	3	—	—	—	—	—	—	—	—	—	3	6	6	7	9	11
Harrison	12	11	11	14	11	14	19	20	22	15	15	15	16	12	14	107	109	102	183	178	178
Hinds	34	43	56	20	22	34	89	110	117	37	45	44	42	55	58	460	465	450	682	740	759
Holmes	2	2	3	6	6	4	—	—	—	—	—	—	—	—	—	1	1	1	9	9	8
Humphreys	1	1	1	3	3	3	1	1	1	—	—	—	—	—	—	—	—	—	5	5	5
Itawamba	2	2	2	1	2	4	—	—	—	—	—	—	—	—	—	1	1	—	4	5	6
Jackson	9	6	5	10	15	16	7	10	10	7	9	12	5	5	5	35	39	45	73	84	93
Jasper	3	3	3	1	1	2	—	—	—	—	—	—	—	—	—	2	1	—	6	5	5
Jefferson	1	1	1	—	—	1	2	1	1	—	—	—	—	—	—	3	1	2	6	3	5
Jeff-Davis	1	1	1	—	—	1	—	—	—	—	—	—	—	—	—	2	1	2	3	2	4
Jones	10	13	12	8	10	9	1	1	1	3	3	4	1	2	3	34	31	33	57	60	62
Kemper	—	1	1	—	—	1	—	—	—	—	—	—	—	—	—	1	1	—	1	2	2
Lafayette	2	2	3	2	3	3	4	5	5	3	3	3	1	1	2	13	14	14	25	28	30
Lamar	2	2	1	1	1	2	—	—	—	—	—	—	—	—	—	2	1	—	5	4	3
Lauderdale	2	4	4	19	13	20	12	12	11	11	11	11	7	9	9	59	67	65	110	116	120
Lawrence	—	1	1	2	1	1	—	—	—	—	—	—	—	—	—	1	1	—	3	3	2
Leake	1	1	1	6	5	6	—	—	—	—	—	—	—	—	—	2	1	—	9	7	7
Lee	4	5	3	9	9	9	7	6	10	6	7	7	4	5	5	35	40	45	65	72	79
Leflore	2	2	3	2	3	4	1	2	3	4	4	4	1	1	1	20	18	20	30	30	35
Lincoln	3	4	4	2	4	6	—	1	2	—	—	1	1	1	1	10	8	7	16	18	21
Lowndes	2	4	3	4	3	3	4	5	5	3	4	3	3	5	4	25	20	23	41	41	41
Madison	5	7	5	5	5	6	1	—	—	—	—	—	—	—	—	2	2	2	13	14	13
Marion	2	2	4	1	1	1	—	—	—	1	1	1	—	—	—	7	8	7	11	12	13
Marshall	—	2	2	3	3	3	1	1	1	—	—	—	—	—	—	5	5	4	9	11	10
Monroe	1	1	2	3	5	6	1	1	1	3	3	3	3	4	4	11	10	7	22	24	23
Montgomery	1	1	1	1	1	2	—	—	—	—	—	—	—	—	—	1	1	—	3	3	3
Neshoba	—	—	1	4	4	6	—	—	—	—	—	—	—	1	—	1	3	1	5	8	8
Newton	3	3	2	2	3	6	—	—	—	—	—	—	—	—	—	2	2	1	7	8	9
Noxubee	—	—	—	3	4	4	—	—	—	—	—	—	—	—	—	2	—	1	5	4	5
Oktibbeha	2	2	2	7	8	8	1	1	3	1	1	1	1	1	2	6	9	10	18	22	26
Panola	4	4	2	6	7	7	—	1	1	—	1	2	—	—	—	3	4	4	13	17	16

TABLE 2 *continued*

County	Family Practice			General Practice			Internal Medicine			Ob-Gyn†			Pediatrics‡			Others and Unknown			Total		
	'75	'76	'77	'75	'76	'77	'75	'76	'77	'75	'76	'77	'75	'76	'77	'75	'76	'77	'75	'76	'77
P. River	4	4	4	4	5	5	—	—	—	2	2	2	—	—	—	3	7	5	13	18	16
Perry	—	—	—	3	3	3	—	—	—	—	—	—	—	—	—	—	—	—	3	3	3
Pike	8	8	10	2	2	4	2	2	2	4	6	5	3	3	3	12	15	11	31	36	35
Pontotoc	—	—	—	4	4	5	—	—	—	—	—	—	—	—	—	3	2	1	7	6	6
Prentiss	1	—	—	5	6	6	1	—	—	1	1	1	—	—	1	4	6	4	12	13	12
Quitman	1	1	1	2	2	2	—	—	—	—	—	—	—	—	—	1	1	1	4	4	4
Rankin	3	3	4	5	5	6	1	2	4	3	3	8	3	4	3	20	21	24	35	38	49
Scott	2	2	1	6	4	7	—	—	—	1	1	1	—	—	—	2	2	—	11	9	9
Sharkey	—	—	—	1	1	3	—	—	—	—	—	—	1	1	1	1	1	—	3	3	4
Simpson	4	3	3	4	5	6	—	—	—	1	1	—	1	1	—	4	4	2	14	14	11
Smith	2	3	2	2	1	2	—	—	—	—	—	—	—	—	—	—	—	—	4	4	4
Stone	2	2	2	1	1	—	—	—	—	1	—	—	—	—	—	1	1	1	5	4	3
Sunflower	5	5	5	3	3	4	—	—	—	—	—	—	—	—	—	4	6	4	12	14	13
Tallahatchie	—	—	—	4	4	5	—	—	—	—	—	—	—	—	—	3	3	—	7	7	5
Tate	2	2	—	3	3	6	—	—	1	—	—	1	—	—	—	1	1	2	6	6	10
Tippah	2	2	2	5	4	6	—	—	—	—	—	—	—	—	—	2	1	—	9	7	8
Tishomingo	2	3	3	2	3	3	—	—	—	—	—	—	—	—	—	10	8	6	14	14	12
Tunica	1	1	1	1	1	3	—	—	—	—	—	—	—	—	—	2	5	2	4	7	6
Union	3	3	5	2	2	1	—	—	—	—	—	—	—	—	—	4	5	4	9	10	10
Walthall	1	1	1	3	3	4	—	—	—	—	—	—	1	1	1	1	3	2	6	8	8
Warren	3	3	3	3	3	5	11	10	11	7	7	8	5	7	8	31	29	28	60	59	63
Washington	9	8	8	1	1	4	9	8	7	5	6	6	4	4	4	34	37	40	62	64	69
Wayne	—	—	1	2	3	5	—	—	1	—	—	—	—	—	—	4	4	2	6	7	9
Webster	2	2	1	—	1	1	—	—	—	—	—	—	—	—	—	2	2	2	4	5	4
Wilkinson	2	2	1	1	1	1	2	2	2	—	—	—	—	—	1	1	1	3	6	6	8
Winston	1	1	1	5	6	5	—	—	—	—	—	—	—	—	—	1	1	1	7	8	7
Yalobusha	—	—	—	1	1	3	1	1	—	—	—	—	—	—	—	2	4	2	4	6	5
Yazoo	2	3	2	3	4	4	—	—	—	—	—	—	1	1	1	5	4	5	11	12	12

* Refers to those specialties recognized by the AMA as being primary care specialties.
† Includes gynecology, obstetrics, and ob-gyn.
‡ Includes pediatrics, allergy pediatrics, and cardiology pediatrics.

The Mississippi Lung Association, basically an educational organization, has pamphlets, films and other material to help inform patients and physicians about lung diseases and pulmonary conditions in present times when there is a challenge of keeping up-to-date on best treatment for respiratory patients, both hospitalized and clinic-treated. The MLA will supply data to physicians, hospital administrators and health workers. Contact the Christmas Seal Association, P.O. Box 9865, Jackson, MS 39206.

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Mississippi State Medical Association Auxiliary

The President's Report on the 1978 Convention of the AMA Auxiliary

June 18-21, 1978
St. Louis, Missouri

It was my privilege to attend the last eombined meeting of the AMA House of Delegates and Seientific Program. In the future, the House of Delegates will meet in Chieago, IL, while the seientifie programs will be held separately throughout the eountry.

Seven hundred twenty-seven registered Auxiliary members were in attendanee at this most informative and ehallenging eonvention. There were numerous ehanges adopted in the AMA Auxiliary Bylaws which will neeessitate eorresponding revisions in our local MSMA Bylaws in order to eonform and maintain proper assoeiation with the national auxiliary.

Mrs. Chester L. Young, outgoing president, introdueed the new president, Mrs. Manuel A. Bergnes from Pennsylvania, and also the president-eleet, Mrs. Ben Johnson, Jr., from Alabama.

The interesting and diverse program was keynoted by a very dynamie speaker, Mr. Bjorn Seeher, who stressed the importanee and value of aehievement both in Auxiliary undertakings and in our personal lives. He stated that he reeognized he was speaking to a group of aehievers by virtue of the faet those in attendanee represented leadership in their respeetive states.

A noted eeonomist, Mr. Eliot Janeway, was the next leeturer, insisting that the best buffer to our present-day inflation problem would be for medieine, without government intervention, to offer its great serviee to our foreign neighbors at top fees.

A nutrition expert, Dr. Elizabeth Whelan, stated that the average Ameriean diet is, in reality, very adequate, needing few or no supplements. She explained that aetually the major health problem is ereated by exeessive food ingestion and she advoeated moderation in all eating habits.

Joint programming with the AMA Counеil on Continuing Physieian Edueation offered *The Physician's Marriage—Joys and Sorrows*, and *Psychology/Biology: Origins of Maleness and Femaleness.*

The highlight of the entire eonvention, I felt, was a report from the AMA-ERF Committee. We were told that the total given for distribution by this eommittee was 2.7 million dollars. Of this amount, more than half, or $1,577,372.53, was eontributed by the Auxiliary. We are justly proud of this aehievement!

My own personal honor eame when I was elected as Southern Regional representative on the AMA Auxiliary Nominating Committee, a position never before held by a Mississippian.

I look forward—with the help of eaeh MSMA member—to a rewarding year of serviee to the medieal profession for the benefit of all residents of our state.

Mrs. G. Samuel Rowlett, Jr.
President, MSMA Auxiliary



The President Speaking

AMA Encourages New Blood

CARL G. EVERS, M.D.

Jackson, Mississippi

In voting a 50 per cent, one-year cut in AMA membership dues for physicians first entering practice, the association's House of Delegates did a good turn for all physicians.

The reduction will manifestly bring in more new practitioners, thus giving the AMA a broader base of support and making it more truly representative of the medical profession.

Consequently, the AMA will be even more effective as an organization that sets and protects medical standards, strives for more and better public health, and represents doctors in coping with government, insurers, hospitals, and the media.

The dues cut—adopted at the association's annual convention in June—means physicians during their often hard-pressed first year of practice will be paying $125 as contrasted with the $250 regular dues and the $35 paid by housestaff.

The membership gain resulting from the dues cut is expected to reach almost 5,000 in five years.

Increased enrollment by physicians of all ages, and in all branches of medicine, is needed if our federation—numerically and financially—is to sustain its strength in the face of constant challenges.

A survey cited in a Board of Trustees report to the House showed that the $250 dues—rather than any lack of awareness of AMA activities—have been a major obstacle to new-practitioner membership.

The report said:

"Ninety-three per cent of non-member students, 85 per cent of non-member residents, and 88 per cent of non-member practicing physicians have specific perceptions of what the AMA does as an organization. For the most part, these perceptions center around lobbying, representing doctors, and medical-education activities."

On the other hand, only 31 per cent of the residents surveyed (members and non-members) said they would sign up at the $250 rate, as compared with 42 per cent at the $125 rate.

So in numerous instances, the $125 rate will stimulate retention of housestaff and students who have increasingly poured into the AMA since its doors opened to them in 1972 and 1973 respectively. Their combined dues-paying membership jumped from 3,000 in 1973 to 28,094 last year.

They've had the opportunity to see how effective the federation is, and to be influential in that effectiveness. In government and elsewhere, the AMA is respected or attacked chiefly because it is medicine's only general spokesman and doer. And the younger physician's contribution to our impact dates back to our association's very beginning.

It goes back most notably to Dr. Nathan Smith Davis, who was only 29 when he spun the organizational wheels that made him "the Father of the American Medical Association."

All of us should endeavor to bring more young physicians into the AMA and our state and county medical societies—to help ensure the future vitality and stamina of organized medicine. ★★★

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XIX, Number 8
AUGUST 1978

It's Your Journal

Your editorial staff would like to make your Journal MSMA as interesting as possible. We were particularly pleased a few years ago when a survey was made and the number of respondents exceeded our hopes. The comments generally were favorable and only a very few stated they seldom read it.

Lately, due to a decrease in advertising, the JOURNAL has of necessity been smaller—a situation peculiar to all state journals. Despite this we try to print that in which you profess most interest.

We solicit your comments and suggestions. Letters to the editor will be printed if the staff feels they are of sufficient general interest.

You may possibly help when you thank pharmaceutical representatives when you notice one of their ads in the JOURNAL.

W. MONCURE DABNEY, M.D.
Editor
Crystal Springs, MS

LETTERS

SIRS: The June 1978 issue of your publication contains a "Newsletter" item concerning our recently filed rate decrease for the excess portion of our medical professional liability policy. The item states "This is the first year since 1975 that St. Paul hasn't filed for a rate increase." That statement is inaccurate.

We did make a rate filing in 1977 which produced a rate decrease for each of the first three years of the five year claims-made rating structure. Rate increases were filed only for the fourth and fifth year of the claims-made rating structure which was done to reflect the lengthening reporting pattern of claims in Mississippi.

In 1977 most St. Paul-insured doctors were changing from their second to third year of claims-made. Therefore the majority of our insureds benefited from a rate reduction last year. Those doctors paid less for the renewal of their policy in 1977 than had been anticipated they would pay based on the rate filings made in the previous year, 1976.

Out of fairness to your readers and to the St. Paul, we would appreciate your clarifying this situation in the next issue of your publication.

JON A. ROEDER, *Professional Liability*
Risk Management Officer
St. Paul Fire and Marine Insurance Co.

SIRS: In preparation for a September meeting of the National Institute of Allergy and Infectious Diseases to consider the feasibility and advisability of making the insect sting kit available to certain trained categories of medical and lay persons, without a specific prescription by a physician, I would be interested in receiving information and comments by the reader of this journal on the following questions:

1. Have you any knowledge of a fatal reaction to an insect sting or drug or food? If so, I would appreciate as much detail as possible, including information concerning the time interval between contact with the offending agent and death.
2. If you know of such a fatality or fatalities, in your estimation, would an immediate subcutaneous injection on the scene of a premeasured dose of epinephrine 1 : 1000 (0.3 cc to 1.5 for adult, 0.2 to 0.3 cc for children) have afforded a different outcome?
3. Have you any knowledge of adverse effects of subcutaneous injections of epinephrine 1 : 1000 in the above dosages? If so, again I would appreciate as much detail as possible.

We would certainly appreciate any information you can supply.

CLAUDE A. FRAZIER, M.D.
Doctors Park—Bldg. 4
Asheville, NC 28801

POSTGRADUATE CALENDAR

Sept. 21-22, 1978
ALLERGY FOR THE GENERALIST
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine and the University Medical Center Division of Continuing Health Professional Education; the University of Tennessee Center for the Health Sciences College of Medicine; and the Vanderbilt University School of Medicine Division of Continuing Education.

Coordinator: Bernard Booth, M.D., clinical associate professor of medicine, University of Mississippi School of Medicine.

This two-day seminar for the generalist will be presented by a guest faculty. Fee: $85.00. Credit: 16 contact hours, 1.6 CEU, Category 1, AMA; AAFP.

FUTURE CALENDAR

Oct. 6-7, 1978
ADVANCED CARDIAC LIFE SUPPORT
University Medical Center, Jackson

Oct. 9-13, 1978
PRACTICE OF ELECTROCARDIOGRAPHY
University Medical Center, Jackson

Oct. 26-27, 1978
ARTHRITIS SEMINAR
University Medical Center, Jackson

Nov. 10-12, 1978
FAMILY PRACTICE REVIEW
University Medical Center, Jackson

Nov. 10, 1978
UPDATE: PITUITARY SYMPOSIUM
University Medical Center, Jackson

Dec. 2, 1978
DIAGNOSIS, TREATMENT AND REHABILITATION OF PATIENTS WITH UPPER ARM PROBLEMS
Methodist Rehabilitation Center, Jackson

All continuing education correspondence should be addressed to: Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216.

DEATHS

COTTRELL, HUGH B., Jackson. Born Pickens, MS, Jan. 22, 1906; M.D., Tulane University School of Medicine, New Orleans, 1932; interned USPHS, Norfolk, VA, one year; MPH, Johns Hopkins School of Public Health, Baltimore, MD, 1935; died June 21, 1978, age 72.

RILEY, GEORGE E., Jackson. Born Houston, MS, July 20, 1898; M.D., Johns Hopkins University School of Medicine, Baltimore, MD, 1935; interned U. S. Marine Hospital, New Orleans, LA, one year; died June 13, 1978, age 79.

NORWOOD, CARL W., Corinth. Born Mt. Sterling, AL, Jan. 10, 1892; M.D., University of Tennessee School of Medicine, Memphis, 1914; interned Memphis General Hospital, one year; died June 14, 1978, age 86.

PERSONALS

GLENN HARRIS BENNETT has associated with J. V. BRUCE of Tishomingo in the practice of family medicine at the Tishomingo Clinic.

GRIFFIN BLAND of Gulfport spoke on the history of orthopedic surgery at the dinner meeting of the Coast Counties chapter of the Mississippi Medical Assistants.

THOMASINA BLISSARD of Jackson announces the relocation of her office to Suite 208-B, 4750 McWillie Drive for the practice of general psychiatry and psychoanalysis.

THERESA L. BUCKLEY of Biloxi announces her association with the Gulf Coast Surgical and Diagnostic Center, P.A. in Ocean Springs for the practice of ophthalmology.

ERNEST N. CHARLESWORTH has associated with JAMES H. MELVIN of Jackson in a partnership to practice dermatology at 514-G East Woodrow Wilson Avenue.

MICHAEL COLEMAN has joined the medical staff of Greenwood Leflore Hospital for the practice of ophthalmology.

A. WALLACE CONERLY of Jackson and UMC is the American Thoracic Society's appointee to the board of trustees, National Board of Respiratory Therapy. He will serve a four-year term.

MICHAEL C. DE BERARDINIS of Houston announces that he acts as urology consultant to Oktibbcha County Hospital in Starkville and the community of Starkville on Mondays only. His primary practice location is at Doctors Park in Houston.

VERNON W. DOSTER announces the opening of his office for the practice of obstetrics and gynecology at 319 East Main Street in Starkville.

DANIEL H. DRAUGHN of Jackson announces the association of CHARLES S. KNIGHT in the practice of neonatology at Woman's Hospital, 1026 N. Flowood Drive.

ROBERT E. ESTESS has associated with JAMES S. MCILWAIN of Clinton for the practice of family medicine at 901 Highway 80 East in Clinton.

HARRY FULCHER of Jackson was re-elected president of the Jackson Music Association at the annual meeting at the King's Inn.

The Surgical Clinic, P.A., of Jackson announces the association of WILLIAM J. GIBSON, JR., for the practice of general surgery and oncology at 1600 North State Street.

R. W. HARRISON of Yazoo City has been re-elected to serve on the 27 member board of directors of the Mississippi Lung Association. JOHN BUSEY of Jackson is first vice president and these physicians are also on the board: MARIAN GODBEY of Aberdeen, ALTON COBB, ROLAND ROBERTSON, CLYDE WATKINS, G. BOYD SHAW and GUY CAMPBELL, all of Jackson.

VERNER S. HOLMES of McComb is being honored with a number of events on Aug. 16. The programs are being sponsored by the Chamber of Commerce and the Southwest Mississippi Regional Medical Center board of directors and medical staff.

W. CECIL JOHNSON of Meridian announces the relocation of his office to 1425 22nd Avenue for the practice of general and colo-rectal surgery.

DANIEL W. JONES has opened his offices at The Medical Center, 535 Fifth Avenue in Laurel for the practice of internal medicine.

ALBERT RAY LEE, JR., announces the opening of his office at 1211 Magnolia Avenue in the Pittman Clinic at Tylertown for the family practice of medicine.

GLENN F. MORRIS, THOMAS R. BRYANT, and ISAAC AULTMAN of Jackson announce the formation of the Family Medical Group, with new offices located at Doctors' Hospital Medical Plaza, Suite 101, 2969 University Drive.

THOMAS D. PAINE has associated with The Jackson Heart Clinic, P.A. for the practice of cardiology and cardiac catheterization at St. Dominic Medical Offices, Suite 515, 971 Lakeland Drive in Jackson.

BRUCE RAFFEL has associated with MILLARD S. COSTILOW and DAVID L. MEADOWS of Carrollton for the practice of family medicine. The three physicians will rotate between the Winona Medical and Surgical Clinic and the Carroll County Clinic.

KELLY SEGARS of Iuka is serving as chairman of the Medical Alumni Guardian Society of the University of Mississippi Alumni Association.

ROLAND E. SIEGLER announces the opening of his office for family practice at Doctors Park, 105 Hillcrest Drive in Houston.

EARL T. STUBBLEFIELD of Jackson announces the relocation of his office to 1050-B North Flowood Drive for practice of obstetrics and gynecology.

JAMES ROY TODD, JR., of Natchez recently held the grand opening and dedication of the Todd Medical Clinic at 500 N. Pine Street in Natchez.

RALPH T. WICKER of Hattiesburg announces the relocation of Neurological Associates, P.A. to 2707 Camp Street in Hattiesburg.

CECIL T. WILLIAMS, JR., of Laurel is president of the Mississippi Heart Association for 1978-79 and WALTER H. ROSE of Indianola is vice president.

HARRY SCHMIDT, JR., of Biloxi and WILLIAM PONTIUS of Ocean Springs were named to the MHA board of directors.

NEW MEMBERS

CRAWFORD, BENJAMIN L., III, McComb. Born Tylertown, MS, April 23, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned Baylor University Medical Center, Dallas, TX, one year; ob-gyn residency, University of Tennessee, Memphis, 1973-76; elected by South Central Medical Society.

HENRY, JOHN KELLY, Meridian. Born Braxton, MS, Jan. 2, 1926; M.D., Washington University School of Medicine, St. Louis, MO, 1950; interned University of Alabama & Jefferson-Hillman Hospital, Birmingham, AL, one year; elected by East Mississippi Medical Society.

MEDICAL ORGANIZATION

MMFES Reports Phenomenal Growth

The Mississippi Medical Fraternal and Educational Society reports a continued increase in physicians covered by the society's professional liability program.

Effective July 1, the society began underwriting the 275 member housestaff of the University Medical Center bringing the total number of members covered by the society at this time to over 700.

The society began its professional liability program in December 1978. Based on present trends MMFES will write over 1,000 physicians or 50 per cent of the physicians in Mississippi by the end of 1978. This is a first year growth rate unmatched by any previous professional liability underwriter in the state.

AMA Considers MSMA Resolutions

MSMA resolutions urging the American Medical Association to withdraw support for its "Comprehensive Health Insurance Act of 1977" and to seek the labeling of alcoholic beverages as habit forming and harmful to one's health received favorable consideration at the recent annual meeting of the AMA House of Delegates in St. Louis.

The MSMA resolution on NHI, along with similar resolutions from several other states, was referred to the AMA Board of Trustees to determine if AMA support for NHI was necessary or not. The House of Delegates directed that if an AMA-sponsored NHI bill is recommended by the Board it should be circulated to the members of the House prior to the AMA's December meeting so it may be studied in detail. During discussion of the AMA's present support of an NHI bill, several delegates referred to the passage of Proposition 13 in California and the possibility of an emerging "taxpayers' revolt" that would mitigate against passage of NHI.

MSMA's resolution on labeling alcoholic beverages received unexpected support from the American Psychiatric Association and a similar resolution from that organization was adopted by the House of Delegates to read "Resolved that the AMA recommend that containers of all alcoholic beverages be required to bear the following statement on their labels: 'Alcohol may be injurious to your health and, if consumed during pregnancy, to the health of unborn children.' "

On another matter of concern at MSMA's recent 110th Annual Session, the AMA House of Delegates refused to adopt recommended revisions in the "AMA Principles of Medical Ethics." Instead the revisions were referred to an *ad hoc* committee of the House for further study in cooperation with the AMA Judicial Council which had proposed the revisions.

MPAC Supports State Political Winners

The Mississippi Medical Political Action Committee has successfully supported all incumbent Mississippi House members who were opposed during their recent party primaries. In addition to supporting Representatives Whitten, Bowen and Montgomery, MPAC has supported John Hampton Stennis in his successful Democratic primary bid for the Fourth Congressional seat vacated by Thad Cochran and Maurice Dantin in his Democratic second primary victory over Cliff Finch.

The MPAC Board made its decision in each instance after conferring with colleagues in their respective districts and considering candidates' votes on medical issues and chances for election.

The MPAC Board will meet in August to consider candidates to support in the November general election.

Blue Cross-Blue Shield Covers Drug Addiction Treatment

Blue Cross and Blue Shield of Mississippi has announced that effective July 1, 1978, it has begun allowing benefits up to $1,500 per calendar year under its local basic contracts for treatment of drug addiction. Benefits will be paid for services on or after July 1, 1978, in accordance with the type contract held by each member until the maximum of $1,500 has been provided.

A few of the Plan's contracts provide regular benefits for treatment of drug addiction and these will not be affected by the aforementioned administrative liberalization.

Miss. Baptist Medical Center Plans Cardiovascular Symposium

The Mississippi Baptist Medical Center has set its annual cardiovascular symposium for Sept. 22-23 at the Downtown Holiday Inn in Jackson.

Featured speakers will be Dr. Frederick Cobb, associate professor of medicine, Duke University Medical Center; and Dr. Albert Oberman, director, division of private medicine, and professor, department of public health, University of Alabama, Birmingham.

For further information contact Dr. Martin McMullan, 1600 North State Street, Jackson, MS 39202.

Physicians Attend CME Day at Medical Center



Physicians from all parts of the state gathered in Jackson June 14 for the annual Continuing Medical Education Day sponsored by the University of Mississippi School of Medicine Department of Family Medicine. Among participants were, from left, Dr. John Hey of Greenwood, Dr. Wilfred Gillis, UMC professor of family medicine and department chairman, Dr. Michael Foose of Yazoo City and Dr. Richard Field of Centreville.

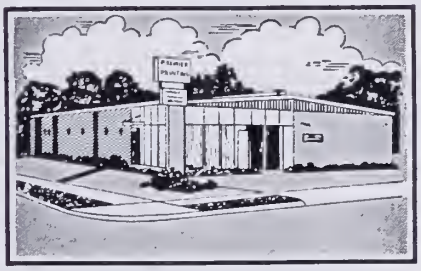
Removal of Parental Consent Is Urged

The Mississippi Advisory Council on Drug Abuse and the Mississippi Advisory Council on Alcohol Abuse have recommended support for legislation to remove the requirement of parental consent for minors 15 years of age and older to receive drug, alcohol or mental treatment from a physician or psychologist.

The councils' recommendation has been submitted to the Mississippi Board of Mental Health for introduction during the 1979 Regular Session of the Mississippi Legislature.

PRINTING — OFFICE SUPPLIES

EQUIPMENT — FURNITURE



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Index to Advertisers

Burroughs Wellcome Co. 10B

Canton Exchange Bank 6
Citizens Bank and Trust Co. 14

Dermik Laboratories second cover
Disability Determination Services 11

Harreld Chevrolet-Oldsmobile 7
Hill Crest Hospital 10

Eli Lilly and Co. 12

Mead Johnson Laboratories 154A, 154B

Premier Printing Co. 19

Riverside Hospital 8
Roche Laboratories 3, third and fourth covers

Smith Kline and French 10A

The Upjohn Company 18
Thomas Yates and Co. 4

IN CONCLUSION

A bill to promote disease prevention and inform the public about good health practices was introduced by Sen. Edward Kennedy (D-Mass.). The bill, in part, would provide grants to states for programs aimed at the five leading causes of death and disability and calls for nutritional labeling on all foods and a comprehensive antismoking campaign. AMA Trustee Lowell H. Steen, M.D., said the association is "basically supportive" of the legislation, although the AMA has "some reservations" about certain provisions in the bill.

The Drug Regulatory Reform Act would be an unjustified intrusion into the practice of medicine, the AMA said in a debate with FDA. The administration's proposal to overhaul FDA "reflects a perception that the interests of the patient and the interests of the physician are not the same and therefore the government must intervene to 'protect' the patient," AMA said. "We do not believe that perception is correct. Furthermore the bill implies that the bureaucracy in Washington is the proper source of medical decisions regarding individual patients."

To aid those with physical disabilities, a new edition of Mealtime Manual for People with Disabilities and the Aging has been revised by the Institute of Rehabilitation Medicine, the New York University Medical Center and the Campbell Soup Company. Copies of the new 269 page manual cost $3.25 each and are available by mail order (Box 38, Ronks, PA 17572). The book includes specific information on food preparation for handicapped or disabled people and includes suggestions on basic kitchen design, serving food, entertaining, shopping and managing alone.

California's proposition 13 and other tax reform efforts under consideration around the country may and probably will have important effects on government efforts to pursue a national health insurance proposal. President Carter is reported to have delayed introduction of any definitive proposal until next year. There may be a "discussion outline" and a presentation of "principles" this year, but the continuing inflation pressure and the taxpayer rebellion are proving to be strong deterrents to a national health insurance push at this time.

Widespread theft by hospital employees rivals inflation as a factor in the rising cost of care, industrial security expert Saul D. Aster said recently in Medical Economics. Theft ripoffs account, in part, for huge jumps in security costs, which at some New York hospitals, for example, exceed $500,000 a year. That's about eight times what security cost those institutions in 1950. On another note, food costs per hospital patient day are expected to increase from $16 in 1975 to $22 by 1980 and to $50 by 1990.

LIBRARY

AUG 17 1979

NEW YORK ACADEMY
OF MEDICINE

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

Her next attack of cystitis may require

the Bactrim™ 3-system counterattac

2EAST 103RD ST
NEW YORK N.Y.
10029



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introit colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

BALCONY

September 1978

Journal of the State Medical Association

Mississippi



Contents:

Frequency of Drug Administration: A Prime Factor in Patient Compliance and Health Care Cost

Brenner Tumor of the Ovary—Ultrasound Findings

ACNE'S ANXIETY





BENZAGEL® 5% Acne Gel 10% Acne Gel

(5% or 10% benzoyl peroxide, 6% polyoxyethylene lauryl ether, 40% alcohol)

Early visible improvement helps to relieve anxiety and promotes patient cooperation—Simple and pleasant to use

- Benzoyl peroxide in a special alcohol gel base—Reliable and predictable, imparts a pleasant cooling sensation with controlled drying of sebaceous oils. Accelerates desquamation.
- "BP base/bond" for uniform therapeutic deposition of benzoyl peroxide—Reduces burning sensation on application, for greater patient acceptance.
- Effective antibacterial and comedolytic action—Rapid improvement is seen, often within two weeks.

BENZAGEL® a basic component of acne therapy

Description: 5% or 10% benzoyl peroxide, 6% polyoxyethylene lauryl ether and 40% alcohol in an astringent gel containing colloidal magnesium aluminum silicate, hydroxypropyl methylcellulose, citric acid, fragrance and purified water.

Action: Provides drying, desquamative and antiseptic activity.

Indication: An aid in the treatment of acne

Dosage and Administration: Wash affected areas prior to application. Apply once or more daily or as directed by physician

Contraindications: Should not be used by patients having known sensitivity to either benzoyl peroxide or polyoxyethylene lauryl ether

Precautions: For External Use Only. Not for ophthalmic use. Keep away from eyes and mucosae. Very fair individuals should begin with a single application at bedtime allowing overnight medication. May bleach colored fabrics. Keep this and all other medications out of the reach of children

Caution: Federal law prohibits dispensing without prescription

How Supplied: Plastic tubes, 1½ oz. and 3 oz.

For Patient Starters
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JOURNAL of the Mississippi
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CONTENTS

ORIGINAL PAPER

Frequency of Drug Administration: A Prime Factor in Patient Compliance and Health Care Cost **161** Richard G. Fischer, Pharm.D., Jackson, MS

SPECIAL ARTICLE

Radiologic Seminar CLXXXIV: Brenner Tumor of the Ovary—Ultrasound Findings **168** Charles O. Williams, M.D., Greenwood, MS

EDITORIAL

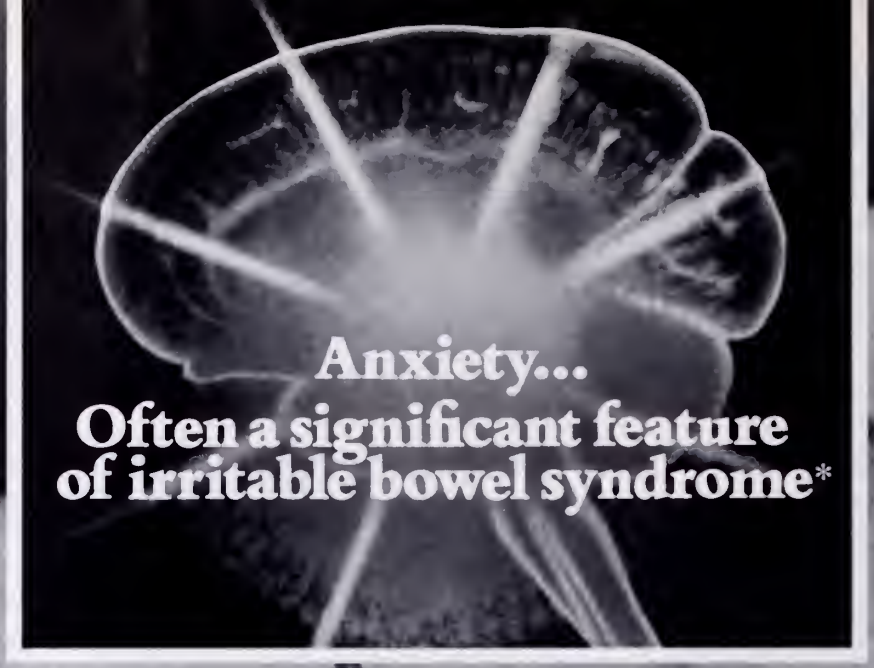
Poisonous Snakebite **171** George H. Martin, M.D., Vicksburg, MS

THIS MONTH

The President Speaking **170** CPE—How Much of a Good Thing Is a Good Thing?

Medical Organization **175** MSMA Board Considers Full Agenda at Regular Summer Meeting in Tupelo

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Final classification of the less-than-effective indications requires further investigation.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Interstate Scientific Assembly Set for Washington, DC

The 63rd Annual International Scientific Assembly of Interstate Postgraduate Medical Association will be held at the Washington Hilton Hotel, Washington, DC on Oct. 23-26, 1978. This program is designed for primary care physicians practicing in the United States and Canada. It has been planned cooperatively with the District of Columbia Academy of Family Practice; University of Maryland, Baltimore; Howard University and Georgetown University, Washington, DC and provides 24 hours of prescribed — 4 elective, credits for members of the American Academy of Family Physicians. Also credit toward the AMA Physician's Recognition Award is provided through attendance.

The program consists of lectures, informal group discussions, "live" closed-circuit TV and medical movies on a variety of topics with major emphasis on rheumatology, gastrointestinal problems, pediatrics, infectious diseases — bacterial and viral, cardiology and an update on current trends and technology. Guest lecturers include: Dr. Richard G. Farmer of the Cleveland Clinic Foundation on Clinical Problems in Inflammatory Bowel Disease; Dr. Hillier L. Baker, Jr. of the Mayo Clinic on Recent Innovations in Diagnostic Imaging of Gastrointestinal Disease; Dr. W. Hugh Missildine of the Ohio State University College of Medicine on The "Mutual Respect" Approach to Child Guidance; Dr. Leonard Scherlis of the University of Maryland Hospital on Coronary Artery Bypass Surgery: A Critical Review; Dr. Nanette K. Wenger of the Emory University School of Medicine on Rehabilitation of the Patient After Myocardial Infarction; Dr. Ray W. Gifford, Jr. of the Cleveland Clinic Foundation on Is Treatment of Hypertension Worthwhile; Dr. John L. Ochsner of the Ochsner Clinic on Arterial Reconstruction of the Lower Extremities; Dr. Arthur C. Guyton from the University of Mississippi Medical Center on Physiology of Blood Pressure Regulation and Hypertension; and numerous other lecturers from the University of Maryland, Howard University and Georgetown University.

The assembly is open to any licensed physician in the United States and Canada for a fee of $75.00 in advance or $100.00 at the meeting. Those interested in the meeting and hotel forms should write to: Alton Ochsner, M.D., Program Chairman, Interstate Postgraduate Medical Association, P.O. Box 1109, Madison, WI 53701.

An open letter to Physicians

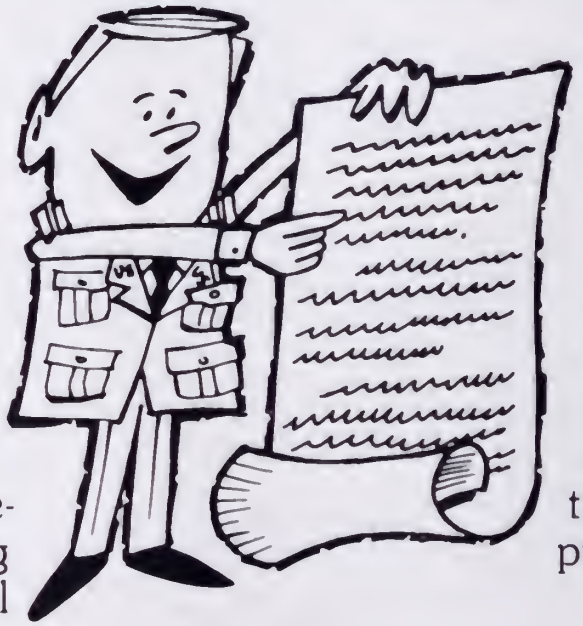
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NEWSLETTER

September 1978

Dear Doctor:

Central Medical Society plans to expand its patient referral service to include referrals to patients seeking "second surgical opinions." The society, encompassing the Jackson-central Mississippi area, will publicize the new service through radio, TV and newspaper advertisements. Information about the service is available to other MSMA component societies and hospital medical staffs. An article about "second surgical opinions" appears in this issue.

> CHAMPUS has recently announced implementation of a new and shorter claim form to replace its DA Form 1863-2. CHAMPUS notes there was an almost 30% return for additional or correct information with Form 1863-2 and predicts new form will significantly reduce this.

In presenting the President's "NHI principles", HEW Secretary Califano told the press that health care costs are still rising, exceeding the general cost of living. A day earlier the Bureau of Labor Statistics released Consumer Price Index figures showing medical care increase of 0.5% in June while all items index rose by 1.0 per cent. Medical care index increased 0.6% in April and May.

Closing legal loopholes could save HEW $1 billion, HEW Inspector General Thomas Morris recently told Congress. He recommended it be made a crime to steal HEW grant and contract money and to bribe a nonfederal Medicaid or Medicare official. Morris' office is probing possible "kickbacks" by residents in teaching hospitals who bill Medicaid for patient services and share payments with hospital or teaching physicians.

Physicians who "routinely" waive collection of coinsurance or deductibles from Medicare patients may find their actual and customary charges reduced by carriers. Section 5220 of HEW's Part B Medicare Carriers' Manual instructs carriers to review such cases and process claims on the basis of amounts physicians actually expect to receive. These amounts will be used in updating customary charge screens.

The most popular sport among physicians who exercise regularly is jogging. Next are tennis and swimming. Golf is not as popular a doctor sport as is generally believed and commented on; only 10.7% of the respondents in an AMA poll said they were golfers. More importantly--only 18.2% say they smoke; the percentage was 30 ten years ago. About a fourth admit to being more than 10 pounds overweight.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

Gastrointestinal Radiology Course Is Planned

The Society of Gastrointestinal Radiologists is conducting a postgraduate course on Diagnostic Imaging of the Gastrointestinal Tract at Tan-Tar-A, Lake of the Ozarks, MO, Oct. 12-15.

The faculty will be drawn from the membership of the Society of Gastrointestinal Radiologists and includes leading academic radiologists from the entire country. Registration fee is $225. The course is co-sponsored by the American College of Radiology with approval for category 1 credit of 13 hours.

Further information and application materials can be obtained from the president of the society, Walter M. Whitehouse, M.D., Department of Radiology, University of Michigan Hospital, Ann Arbor, MI 48109.

Arthritis and Rheumatology Dial Access Announced

Southern Medical Association announces its newest Dial Access Program — on Arthritis and Rheumatology. Providing the most recent diagnostic and therapeutic information on specific problems in arthritis and rheumatology, the new Dial Access Program is available 24 hours a day, seven days a week, at no charge to physicians.

The Dial Access System is a method of medical consultation by means of tape-recorded messages that are accessible on request through long-distance, toll-free telephone calls. The system is approved for credit toward the AMA Physician's Recognition Award, and by simply listening to these tapes a doctor may accumulate Category V credit.

Catalogs for the new Dial Access Program on Arthritis and Rheumatology may be obtained by writing to SMA, 2601 Highland Avenue, Birmingham, AL 35205.

A Dial Access Program on Infectious Diseases will be ready this fall.

The Southern Medical Association is comprised of 25,000 physicians of all specialties from 16 southern states and the District of Columbia. Organized in 1906, its objective is to develop and foster scientific medicine. The association will hold its 72nd annual meeting, the second largest conclave of medical science in the nation, in Atlanta, Nov. 11-14.

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Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

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Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

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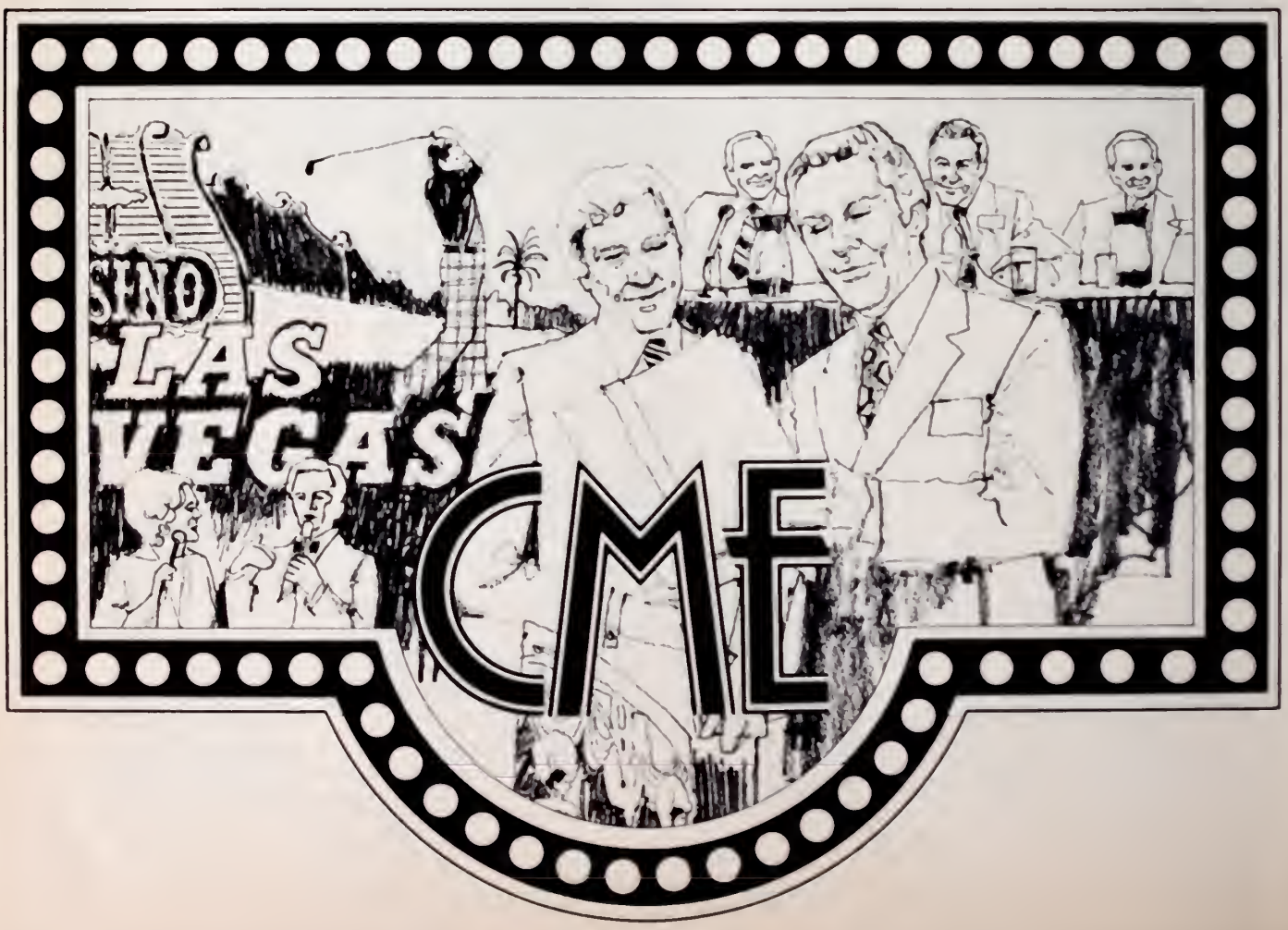
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Who's Responsible for Health Costs?

When asked if they believe health costs are rising more rapidly than costs in general, three in four Americans said "yes" in a recent survey conducted by the Health Insurance Institute.

When asked who was "most responsible" for these rising costs, 27 per cent singled out physicians. Twenty-one per cent thought hospitals were most responsible, while 18 per cent named the public, and 11 per cent said health insurance companies.

AAP Annual Meeting Is Scheduled for This Month

A special scientific session on controversies in pediatrics will be among the presentations when the American Academy of Pediatrics holds its annual meeting, Oct. 21-26 at the Palmer House Hotel in Chicago.

The six-day meeting will feature reports on a wide variety of topics, including high risk pregnancy, drug abuse, parenting, growth disorders, and newborn surgical emergencies. The "controversies" session, scheduled for Thursday, will focus on subjects such as sudden infant death, treatment of childhood diabetes, phenobarbital therapy, and the use of steroids.

The scientific program will open with a series of seminars on Saturday and Sunday on such subjects as hyperactivity, adolescent medicine, learning disabilities, athletic injuries, immunodeficiency disease, and nutrition.

Plenary sessions open to all meeting attendees are scheduled for Monday-Thursday. Sessions will consider such topics as allergy, child development, diseases of the chest, perinatal pediatrics, alternative birth methods, behavioral problems in adolescence and new drugs in the treatment of asthma and infectious disease.

The AAP Sections on Allergy, Cardiology, Child Development, Surgery, Perinatal Pediatrics and others will hold meetings in conjunction with the academy sessions. The Society for Adolescent Medicine and the National Association of Pediatric Nurse Associates and Practitioners will also host educational meetings. Scientific and technical exhibits will be on display at the Palmer House.

The academy is the Pan-American Association of physicians certified in the care of infants, children and adolescents. The AAP has approximately 18,000 members in North and South America.

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DATELINE

Helping Physicians to Manage Stress

New York, NY - Cornell University Medical College announces formation of an Editorial Board of eminent physicians to assist doctors in diagnosing and managing stress in their patients. The seven-member board will develop and direct a 30-month program of professional education, entitled "The Consequences of Stress: The Medical and Social Implications of Prescribing Tranquilizers." The program, eligible for CME credits, will cover all available treatment modalities.

Newborn Intensive Care Is expensive

Evanston, IL - The average cost of insuring that a premature infant will leave the hospital healthy and "normal" is $115,356, according to a report in Pediatrics, American Academy of Pediatrics' monthly journal. Average total cost per nonsurvivor was $14,236. In follow-up developmental/neurological testing at 12 months to 3 years, 70% of the surviving infants were functioning normally. Fifteen years ago, infants weighing 2.2 lbs. or less had a 10% survival rate.

Brain Tumor Primer Will Aid Patients

Chicago, IL - A 40-page "Primer of Brain Tumors" has been published by the Association for Brain Tumor Research and will be provided without charge to brain tumor patients and their families. Booklet describes brain tumors, their symptoms, how they are diagnosed and reviews current methods of both diagnosis and treatment. Parts of the brain are illustrated along with explanations of what functions each controls, in as "lay" language as possible.

Diabetes Association Studies Saccharin Use

New York, NY - The American Diabetes Association has recently concluded that, based on evidence available as of early 1978, there appears to be little justification for placing further governmental restrictions on use of saccharin at the present time. ADA committee examined all of the presently-published findings on human epidemiological studies, mutagenicity testing, and animal feeding experiments with regard to the possible cancer-inducing properties of saccharin.

The Accident Book Is Published

Lansing, MI - Motorists stopping to assist victims of automobile accidents need help, according to the American College of Emergency Physicians which helped produce "The Accident Book." The booklet, 15th in the "Answer Book" series produced by Shell Oil Company, discusses the activities of people who happen upon the scene of an accident. Highlights include where to park, basic first aid procedures, contents of an accident kit for your car, etc.

UMC Adds to Faculty

Five assistant professors and four instructors have joined the School of Medicine faculty at the University of Mississippi Medical Center, according to Dr. Norman C. Nelson, UMC vice chancellor for health affairs and medical school dean.

He announced the summer appointments following approval by the Board of Trustees, Institutions of Higher Learning.

New assistant professors are Dr. Glen R. Graves, pediatrics; Dr. Bobby Jerrell Heath, surgery; Dr. Marjorie H. Hendrickson, anesthesiology; Dr. Walter C. Kruckeberg, preventive medicine (medical genetics); and Dr. James Larry Parker, neurology.

Joining the medical school faculty as instructors are Maureen Althaia Gruich, obstetrics and gynecology; Dr. Nancy Carolyn Lawhon, radiology; Dr. Greer H. Ricketson, radiology; and Dr. Margaret Louise Turkleson, surgery.

Dr. Graves, who attended Millsaps College, earned the M.D. degree at UMC in 1970. He interned and took residency training at the Medical Center in 1970 and 1972 and was a resident at the University of Kentucky Medical Center in 1971. An Army veteran, Dr. Graves has been in private practice since 1974.

Dr. Heath attended Ole Miss, and earned the M.D. at UMC in 1968. He interned at Parkland Memorial Hospital in Dallas from 1968-69. Dr. Health served in the Air Force and was in private practice before returning to UMC in 1972 for surgery residency training.

Dr. Hendrickson comes to UMC from Houston, TX, where she has been assistant professor of anesthesiology at Baylor College of Medicine since 1975. A graduate of the University of Texas in Austin, Dr. Hendrickson earned the M.D. at the University of Texas Medical Branch in Galveston in 1958. She interned at University Hospital and Hillman Clinic in Birmingham from 1958-59, and took residency training at the University of Texas Medical Branch from 1959-61. Dr. Hendrickson was an instructor at the University of Texas Medical Branch in 1961, and served on the staff of M. D. Anderson Hospital and Tumor Institute in Houston from 1962-74.

Dr. Kruckeberg, a postdoctoral fellow at the University of Michigan Medical School since 1973, earned his Ph.D. degree at Washington University in St. Louis in 1973. A graduate of St. Olaf College (Minnesota), Dr. Kruckeberg earned the M.S. degree at Minnesota's St. Mary's College in 1968.

Dr. Parker, also named assistant professor of surgery (ophthalmology), earned the M.D. degree at UMC in 1971. A B.S. graduate of the University of Southern Mississippi, Dr. Parker interned and took residency training at the University of Florida Medical Center in Gainesville. He held a fellowship at Bascom Palmer Eye Institute in Miami from 1976-77, and has been a neurology instructor at the University of Florida Medical Center since 1977. An Air Force veteran, Dr. Parker also attended Louisiana Polytechnical Institute and Northeast Louisiana State College.

Ms. Gruich earned her B.S. in nursing in 1975, and the M.S. in 1978, both at the UMC School of Nursing. She has been a staff nurse at University Hospital since 1974.

Dr. Lawhon, who attended Millsaps College and Mississippi State University, earned the M.D. at UMC in 1971. She interned and took residency training at the Medical Center from 1971-73. Dr. Lawhon served as emergency room physician at St. Dominic Memorial Hospital and a medical consultant for the State Board of Health before returning to UMC in 1975 for further postgraduate training.

A B.A. graduate of Millsaps College, Dr. Ricket-

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Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Viral diseases of the skin (such as vaccinia and varicella); fungal lesions of the skin except candidiasis; history of hypersensitivity to any product component. Not intended for ophthalmic use; should not be applied in the external auditory canal of patients with perforated eardrums; should not be used when circulation is markedly impaired.

WARNINGS: Because of the potential hazard of nephrotoxicity and ototoxicity, prolonged use or use of large amounts of this product should be avoided in the treatment of skin infections following extensive burns, traphic ulceration, and other conditions where absorption of neomycin is possible.

Usage in Pregnancy: Although topical steroids have not been reported to have an adverse effect on the fetus, the safety of topical steroids during pregnancy has not been absolutely established; therefore, do not use extensively on pregnant patients, in large amounts, or for prolonged periods.

PRECAUTIONS: Watch constantly for overgrowth of nonsusceptible organisms (including fungi other than candida). Should superinfection due to nonsusceptible organisms occur, administer suitable concomitant antimicrobial therapy; if favorable response is not prompt, discontinue the preparation until adequate control by other anti-infectives is effected. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid; suitable precautions should be taken. If irritation develops, discontinue the product and institute appropriate therapy.

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For full prescribing information, consult package insert.

HOW SUPPLIED: Available in 15, 30, and 60 g tubes. It is also available in jars of 120 g (4 oz.) for hospital or institutional use only.

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son earned the M.D. degree at the University of Tulane School of Medicine in New Orleans in 1973. He interned at Norfolk General Hospital in Virginia from 1973-74, and took residency training at the Medical Center of Virginia.

Dr. Turkleson, who attended St. Louis University, earned the M.D. degree at the University of Texas Medical Branch in Galveston in 1973. She interned and took residency training at UMC.

Medicaid Abortion Rules Are Issued

The government has issued rules under which federal funds may be used to pay for Medicaid abortions.

The two physicians who certify necessity of the abortion must be financially independent of each other to eliminate conflicts of interest. Under law, federal funds may be used for abortions only when two physicians certify the mother will suffer severe and long-lasting damage.

The name and address of both the victim of rape or incest and the person reporting the crime must be listed. The law allows federal money for abortions in cases of rape or incest if the crime is reported to the police or public health officials within 60 days. Previous regulations did not require the address of the victim.

When physicians certify the mother's health would be affected without an abortion, the address of the patient must be given to state and federal authorities as well as the name.

The HEW Department said the address requirements will enable HEW and state officials "to ascertain the appropriateness of payments for abortions."

Physicians Report Free Care

Physicians still adhere to the principle of caring for all patients, regardless of ability to pay, an American Medical Association opinion poll of doctors indicates.

Most physicians continue to reduce their fees or provide free care to patients who can't pay, says the poll report in the Impact section of a recent issue of the *American Medical News*.

When the need exists, physicians regard it as their ethical professional responsibility to provide services, the poll reveals.

Until the mid-'60s, when Medicare and Medicaid legislation was enacted reimbursing physicians for services to the aged and to the medically indigent, 97 per cent of all responding physicians said they cared for patients without charge or at reduced fees. Even now, with the government programs in place for more than a decade, 83.4 per cent say they make similar concessions to patients who are poor, can't afford health insurance, and are not covered by some state or federal program.

The majority of physicians (67 per cent) were not enthusiastic about the net effect of efforts to turn every patient into a "paying patient" through various government programs.

Two out of three MDs believe the general result has been negative. These doctors say the programs have led to overutilization of medical service and facilities, greatly increased medical costs, eroded the doctor-patient relationship and destroyed patients' dignity and incentive to take personal responsibility for their own health. Only 13 per cent of doctors see the net effect of government programs as generally good.

Bureaucratic red tape makes the programs "theoretically good, but practically bad," said one doctor.

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Medical Center Announces Faculty Promotions

Seven associate professors who became full professors are among 16 School of Medicine and centerwide faculty members promoted this summer at the University of Mississippi Medical Center.

Dr. Norman C. Nelson, UMC vice chancellor for health affairs, announced the promotions following approval by the Board of Trustees, Institutions of Higher Learning.

Medical school faculty moving up to the rank of professor are Dr. Robert R. Smith, neurosurgery; Dr. Robert L. Watson, preventive medicine; and Dr. Myron W. Lockey, surgery (otolaryngology). Dr. Smith joined the Medical Center faculty in 1967. Dr. Watson has been on the faculty since 1964 and Dr. Lockey since 1966.

Centerwide faculty earning promotion to full professor are Dr. Ben H. Douglas, anatomy; Dr. Lanelle G. Gafford, microbiology; and, pharmacology and toxicology faculty members, Dr. Ing Kang Ho and Dr. Asa Thureson-Klein. Dr. Douglas joined the faculty in 1964, and Dr. Gafford in 1957. Dr. Thureson-Klein has been at the Medical Center since 1969, and Dr. Ho since 1975. Centerwide faculty teach students in the UMC Schools of Medicine, Nursing, Dentistry and Health Related Professions, and the graduate programs in the medical sciences.

School of Medicine faculty promoted to associate professor are Dr. J. Tate Thigpen, medicine, and Dr. Fred A. Crawford, surgery. Dr. Thigpen joined the faculty in 1973, and Dr. Crawford in 1976.

Centerwide faculty moving up to the rank of associate professor are Dr. Norman A. Moore, anatomy, and Dr. Harihara M. Mehendale, pharmacology and toxicology. Dr. Moore joined the faculty in 1976, and Dr. Mehendale in 1975.

Five other faculty members moved up to assistant professor. In the School of Medicine they included Dr. Mary B. Coleman, medicine (research); Dr. Michal A. Douglas, neurology; Dr. Steven H. Sanders, psychiatry and human behavior (psychology); and Dr. William D. Mustain, surgery (otolaryngology). Dr. Douglas, Dr. Sanders and Dr. Mustain joined the faculty in 1977, Dr. Coleman in 1975.

Dr. Edward E. Smith, centerwide faculty member from 1960-69 and since 1977, was promoted to assistant professor of pathology.

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AMA Lists Openings for Physicians

Almost 4,000 job opportunities for physicians in Mississippi and other states are listed in the new and expanded third edition of the Opportunity Placement Register of the American Medical Association's Physician's Placement Service.

The updated Opportunity Register is published each quarter, says Daniel K. Harris, director of the AMA Physician's Placement Service. The third edition will be valid through Sept. 30, 1978.

Important features of the register are computer-generated indexes which facilitate finding the most suitable opportunity. This is the first time in the history of the Placement Service that a concise, timely listing of all available U. S. opportunities has been published for physician reference. Information about foreign opportunities is available from the AMA but is not included in the register.

A companion book is a register containing résumés of physicians seeking job opportunities. This book also will be printed each quarter, as a guide to communities, medical groups and other organizations seeking physicians.

Filling a practice opening is predicated upon considerations such as location, type of practice, area of specialization, economic incentives and educational opportunities, Harris points out. Physicians wishing

to explore a practice opportunity listed in the register may do so through the AMA.

"The decision of a physician to seek a new practice opportunity is extremely important and the outcome of this decision will affect the doctor's personal and professional life. The AMA's Physician's Placement Service is established to assist physicians in this undertaking," he says.

HMOs Are Scaled Down

The Senate has approved a scaled-down measure continuing federal aid for Health Maintenance Organizations (HMOs).

Reports of abuses of the HMO program in some areas led the Senate to adopt financial disclosure provisions and other rule tightening. As cleared by the Senate, the HMO program would be extended for three years with a total authorization of $170 million. The original request had been for a five-year extension and $400 million.

Sen. Sam Nunn (D-Ga.), chairman of a special Senate investigations subcommittee, held hearings and issued a report this year criticizing past operations of the HMO program and pointing to instances of abuse and inefficiency. He led a successful drive to pare the size of the bill and to include some of the anti-fraud provisions, securing agreement with Sens. Edward Kennedy (D-Mass.) and Richard Schweiker (R-Pa.) on the limiting proposals in advance of the Senate vote.

Speaking in favor of the bill, Sen. Robert Dole (R-Kan.) said that "unless we monitor much more closely what we have been doing, we may be supporting a program which in the future could prove to rival the nursing home and Medicaid mill scandals about which we have heard all too much in the past."

Hospital Laundry Managers Plan Seminar

The Louisiana and Mississippi chapters of the National Association of Institutional Laundry Managers will co-sponsor an educational seminar, emphasizing cost containment through effective linen use management, energy conservation, personnel management and infection control. One point toward certification will be awarded for every hour of the educational portion of the seminar.

The meetings will be held at the Vieu Carré Motor Lodge in New Orleans, Oct. 26-27, 1978. For more details, contact Mr. Bobbie Butler, 7639 Townsend Place, New Orleans, LA 70126, telephone (504) 242-6254.

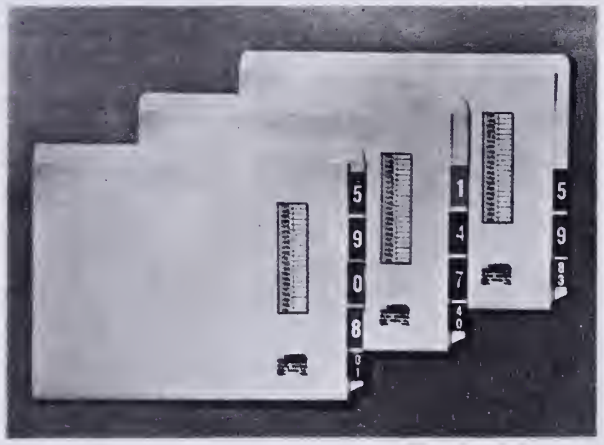
Mississippi Is Lowest in Hospital Rates

A recent survey conducted by the Health Insurance Association of America reveals that Mississippi hospitals have the lowest average hospital semiprivate room rates in the country. The daily rate in Mississippi in January 1978 was $56. Persons in Alaska pay the highest rates — $148 a day, followed by California at $133, Michigan at $130 and New York at $127. To help pay the cost of hospitalization, HIAA reports that some 177 million persons had hospitalization insurance.

In other states contiguous to Mississippi, the HIAA report revealed rates of $80 in Alabama, $67 in Arkansas, $75 in Louisiana, and $72 in Tennessee.

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Adverse Reactions: Nausea, vomiting, cramping, diarrhea, and hypersensitivity reactions (photosensitization and other allergic reactions) have been reported. The gastrointestinal reactions occur more often in older children and adults who have received large doses. Emesis is more frequently seen with Povan Suspension than with Povan Filmseals.

How Supplied: Each Povan Filmseal® contains pyrvinium pamoate equivalent to 50 mg pyrvinium, supplied in bottles of 50 (NDC 0710-0747-50; NSN 6505-00-134-1966). Povan Suspension, a pleasant-tasting, strawberry-flavored preparation containing pyrvinium pamoate equivalent to 10 mg pyrvinium per milliliter, is supplied in 2-oz bottles (NDC 0071-1254-31; NSN 6505-00-890-1093).

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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
September 1978, Vol. XIX, No. 9

ORIGINAL PAPERS

Frequency of Drug Administration

A Prime Factor in Patient Compliance and Health Care Cost

RICHARD G. FISCHER, Pharm.D.
Jackson, Mississippi

WHEN WAS THE last time you had to take a medication on a prescribed schedule, such as four times a day at six hour intervals? Did you remember to take all of your medication at the correct times? If you are like the majority of your patients, you forgot to take your medication on more than one occasion. Forgetfulness has been established as a primary factor associated with noncompliance.[1] This problem is commonly seen in patients being treated for chronic conditions such as epilepsy and psychoses or in asymptomatic diseases such as hypertension.

Studies have shown that the frequency with which a drug is administered is related to the degree of compliance. Ayd[2] was able to demonstrate a significant increase in the percentage of compliant patients when the dosage schedule was decreased from 3 or 4 times daily to once or twice daily. In a retrospective study, Gatley[3] discovered 67 per cent of his patients compliant on a once a day dosing schedule as opposed to only 32 per cent compliant on a four times a day schedule. Intermediate levels of compliance were observed in those on twice or three times a day dose regimens.

What are the practical implications of these facts for you as a physician? Recent studies in the clinical literature raise questions regarding the widely accepted belief that in order for a drug to be effective it must be administered several times a day. Several studies now lend support to single or twice daily dosing with certain drugs. Some have received FDA approval for the new dosing technique and others are currently under clinical investigation pending approval.

It is the purpose of this article to provide you, as a practicing physician, with the facts about this dosing technique so that you may tailor a dosage regimen to suit a patient's lifestyle in an effort to insure a greater degree of compliance.

From the Department of Clinical Pharmacy Practice, School of Pharmacy, the University of Mississippi Medical Center, Jackson, MS.

Frequency of drug administration is discussed as a correlate of patient compliance and health care cost. Numerous clinical studies have demonstrated improved patient compliance and lower cost with less frequent administration schedules. The FDA has recently granted approval for less frequent dosing with certain drugs and others are currently under investigation. Altered-interval dosing for several classes of drugs with efficacy, technique, advantages and disadvantages is discussed. General advantages for this technique, in addition to improved compliance and decreased cost, include greater social and psychological acceptance on the part of the patient, greater control over side effects and decreased cost of administration in institutionalized patients. The primary disadvantages demonstrated to date include decreased tolerance of altered dose schedule in some elderly and debilitated patients, increased gastrointestinal distress for some drugs and for certain agents an increased incidence for selected side effects. Generalizations regarding this dosing method are hard to make and the need to individualize each patient's regimen is stressed.

Several drugs are discussed with elaboration on factors, both pro and con, to be considered before decreasing the frequency of drug administration.

Anticonvulsant Drugs

Anticonvulsant drugs have traditionally been prescribed in divided daily doses. The long plasma

half-lives of several of these drugs (phenytoin — 22 hours, phenobarbital — 4 days) suggests that less frequent administration may be feasible for many patients.[4]

Phenytoin. Phenytoin (Dilantin®), one of the most common drugs employed in the management of convulsive disorders, has been approved by the FDA for administration in a single daily dose. Buchanan[5] in a study of phenytoin kinetics found no significant difference in absorption, steady-state plasma levels, biologic half-life, peak and trough values, or urinary recovery in patients utilizing a three-times-daily dosing schedule versus a once-daily dosage schedule. Since the half-life of phenytoin may vary among individuals, with a reported range of 7 to 48 hours,[6] not every patient will be an ideal candidate for single-dose therapy. Patients who report an increase in seizure activity should have phenytoin serum levels drawn just prior to receiving a dose. This will help the physician determine individual variations in metabolism. Patients with shorter half-lives can usually be controlled on twice a day administration with the majority of the drug administered at bedtime.

Children are more apt to require shorter dosing intervals than adults due to shorter serum half-lives.[7] Curless and co-workers[8] found an average phenytoin half-life of 4.55 hours in 11 young children with seizure disorders. Since the hourly variation in phenytoin serum concentrations is greater in children than in adults it is recommended that phenytoin be administered to young children at least two or three times daily.[7, 9, 11, 13]

The advantages of once-a-day dosing with phenytoin are: social and psychological advantages for school-age children and working adults; increased compliance, and reduced nursing and pharmacy costs in institutions caring for a large number of epileptic patients.[5] Also, by administering the dose in the evening, peak plasma levels and toxicities occur while the patient is asleep.[14] Several patients consuming phenytoin at bedtime have reported morning drowsiness and ataxia. Since peak plasma levels may not be reached for up to 12 hours,[5] these patients probably had maximum plasma levels upon arising in the morning. This problem may be avoided by instructing these patients to administer their dose in the late afternoon or early evening.

Several disadvantages should also be mentioned: occasionally, phenytoin-induced gastrointestinal irritation will be more troublesome with the larger single doses and may preclude its use. Administration with a full glass of water or food generally reduces the irritation considerably.[14] A second disadvantage is that missing one dose on a once daily regimen is much more serious than missing a dose on a multiple dose regimen.

The wide individual variation in half-lives, the higher peak serum levels with the possibility of saturating metabolic enzymes thus leading to accumulation, and a reported average difference of 27.6 per cent between peak and trough levels,[15] lead many to recommend the twice-daily dosage regimen as the optimum dosage schedule.[7, 10-12]

Phenobarbital. Phenobarbital with its long half-life, approximately 2-4 days, may also be considered for once daily administration.[14] A mean elimination rate of 16 per cent per 24 hours has been reported which indicates that a single daily dose of phenobarbital is sufficient when the serum concentration is fully adequate.[9] Since the hourly variation is less when the drug is administered twice daily, some authors still support divided daily dosage.[7]

Phenobarbital elimination, like phenytoin elimination, is more rapid in children than in adults and the serum level is lower for a given mg/kg dosage.[13, 16] Therefore, it is recommended that phenobarbital be given to children in at least two doses daily.[7, 10]

Psychotherapeutic Drugs

Phenothiazines. Compliance with a prescribed regimen in a psychiatric patient is always a practical concern for the physician. Ayd[18] studied the compliance of psychiatric patients on a variety of dosing schedules. His results were striking in that there was a 70 per cent noncompliance rate with q.i.d. dosing, a 60 per cent noncompliance rate with t.i.d. dosing, a 30 per cent noncompliance rate with b.i.d. dosing and only a 7 per cent noncompliance rate with once-a-day dosing. Noncompliance was described as greater than 20-25 per cent of the medication remaining upon pill count.

The phenothiazine drugs are frequently prescribed on a schedule three to five times a day for many years.[17] These drugs also have long biological half-lives and can usually be administered once-a-day after determination of a maintenance dose.

Special slow-release oral preparations (spansules) have no distinct advantage over the ordinary form of the tablet and are most expensive.[17] One possible advantage may be that in the case of an overdose, some of the drug from the spansule form will not be released and can therefore be removed from the gut and intestinal tract.

Several advantages of daily dosing one hour before bedtime may be suggested.[17, 19, 20, 37] First, all of the psychotherapeutics have the potential of

causing sedation. If administered before bedtime this action may be beneficial in helping the patient to sleep which avoids the need for a sedative-hypnotic, therefore decreasing the cost of health care. Second, many of the pharmacological side effects now occur when the patient is asleep and consequently there are less complaints of lethargy, dry mouth, blurred vision and tremor. It has been observed that the incidence of side effects is lower with this dosage schedule than for the same dose given in three divided doses. Third, for inpatients, a single evening dose is more convenient for the patient as well as staff in that considerable nursing time can be saved. Fourth, the likelihood of a medication error may be reduced significantly when drugs are handled only once instead of several times a day. Fifth, a total daily dose of phenothiazine at bedtime reduces the need for antiparkinsonian drugs in many cases. Finally, the administration of single daily doses allows for the use of proportionately less expensive size tablets. Several studies report annual savings in the thousands of dollars by merely switching patients to daily doses.[17, 20, 21]

Exceptions to the daily dosage schedule may include the elderly and physically infirm who cannot detoxify these drugs as rapidly and thus require smaller doses and more frequent administration. The occasional patient who paradoxically reacts with restlessness or insomnia should receive the bulk of the daily drug dosage in the morning.[17]

Benzodiazepines. Clinical studies support once daily dosing of the benzodiazepines after the daily requirement has been adequately determined.[22-24] This is possible due to the accumulation of major active metabolites of these agents which have plasma half-lives in the range of 1 to 3 days.[22, 26] Of the benzodiazepines currently available, only oxazepam (Serax®) and lorazepam (Ativan®) have one-step elimination pathways without active intermediate metabolic products. Therefore, these drugs will not maintain therapeutic plasma levels if administered once a day.

If the decision is made to treat a patient chronically, a single dose at bedtime may prove useful. Most anxious patients are also troubled by insomnia and the bedtime dose should help this complaint since peak plasma levels will occur during the sleeping hours.[24, 25] Small supplemental daytime doses can be employed on a "PRN" basis. This single dose regimen should be used cautiously in the elderly, in patients with respiratory disorders, and others who might be susceptible to hypnotic doses of these agents.[26]

Tricyclic Antidepressants. In recent literature increased attention has been focused on administering a single large bedtime dose of tricyclic antidepressants with the advantage of safety and effectiveness of this practice being stressed.[19] The rationale for prescribing single daily doses of tricyclic antidepressants is supported by the facts that these drugs have long biologic half-lives, their metabolism and excretion proceed at a very slow rate and accumulation of these drugs and their metabolites occurs in various body tissues and a saturation level is reached. These accumulations are then released from the tissues very slowly.[19]

The dosage regimen for the tricyclics should initially be with small divided doses. This regimen increases flexibility in determining the optimum dose, and has also been reported to lessen the impact of side effects.[28] This dosage individualization is an important consideration since steady-state drug levels have been shown to vary up to 36-fold.[27] Unfortunately, incremental dosing has not been adequately recommended in the promotion for several tricyclics such as doxepin (Sinequan®) and amitriptyline. This has led to physicians initiating outpatient therapy with initial large doses of these drugs.[28] The tricyclics may have a stimulatory effect on a few patients, and therefore should not be prescribed for these individuals as a single bedtime dose.[30]

Kales et al[28] reported a study which evaluated the effects of a single 75 mg dose of doxepin administered at bedtime. The patients experienced a marked hangover on awakening in the morning and were extremely drowsy and uncoordinated for several hours. The patients all asked to discontinue the medication after three nights. Another investigator[29] has noted a number of patients complaining of terrifying nightmares, some of which interrupted sleep, while receiving single bedtime doses. The nightmares disappeared when the dosage schedule was changed to divided doses three or four times daily. Thus while it may be advantageous to administer the tricyclics as a single bedtime dose, it is safer and better tolerated when one gradually titrates to the larger bedtime dose.

Another important fact to remember is that single doses above 200 mg of imipramine or the equivalent approaches the level of toxicity (5 mg/kg) for certain people.[29] In patients requiring more than 150 mg of imipramine or its equivalent it is safer to utilize a multiple daily dosing schedule.

Patients may object to taking a large number of pills at one time. This complaint should be eliminated with the advent and approval of new higher-strength dosage forms. Other patients prefer the

psychological reassurance of taking medication throughout the day and refuse to take single daily doses for fear they are not getting medication often enough to benefit them.[19]

Several advantages are promoted for dosing the tricyclic antidepressants in a once a day dosage.[18, 19, 28, 30, 31] First, dosing in the evening often precludes the need for a hypnotic due to the drug's sedative effects. This avoids the sedative side effects observed when the drugs are administered during the day which may be very discomforting and hazardous when performing tasks such as driving an automobile. Frequently patients have discontinued their medication because they were too sleepy during the day. Second, side effects have been reported to be less common and they occur during sleep so that the patient is unaware of pharmacologic effects that would be subjectively annoying and distressing during the waking hours. Third, a single daily dose is more convenient for patients and nurses and usually more economical than are divided doses. Fourth, outpatients are spared the embarrassment of taking drugs in the presence of others at work which makes this schedule more socially acceptable.

In summary, single dose therapy with several of the tricyclics has been approved by the FDA and has been shown in clinical trials to be safe and efficacious. Gradual changeover from a multiple daily dosage schedule is recommended in order to reduce side effects. Patients unable to tolerate single daily doses are often able to continue the medication on a b.i.d. or t.i.d. schedule.

Antihypertensive Drugs

Methyldopa. Methyldopa (Aldomet®) is recommended by the manufacturer to be administered in three or four divided daily doses. Troublesome side effects are frequently associated with chronic therapy. These most commonly include sedation, fatigue, lassitude, dry mouth, and impotence. These side effects, the asymptomatic nature of the disease, the high cost and the inconvenience of the regimen, all contribute to problems with compliance. It is possible that the side effects of fatigue and lassitude and possibly even impotence could be minimized if the total daily dose were taken at bedtime.[32]

In a recent double-blind, crossover study[32] the antihypertensive effectiveness of methyldopa was shown to be similar in 14 patients, whether the drug was administered three times daily or as a single dose. The authors also noted upon subsequent clinical experience that some patients who complained of drowsiness and fatigue on a t.i.d. schedule found these symptoms to be less when the drug was given as a single total dose at bedtime. This study and others[33] suggest that the therapeutic half-life of methyldopa is longer than the observed plasma half-life. Wright et al[32] point out that the long duration of antihypertensive effect in their study with the single daily dose may not be observed in patients on initial methyldopa therapy since all patients they studied were previously controlled on divided dose therapy with methyldopa. In evaluating all antihypertensive studies it must be remembered that normal pressures in hypertensive patients may persist for variable lengths of time after discontinuation of antihypertensive therapy[34] and possibly after decreasing the dose or dosing interval.

Further studies are required to determine whether methyldopa will retain its effectiveness on single dose administration over long periods and whether a single bedtime dose can be used for initiation of therapy. Selected patients placed on single dose therapy to improve compliance or help alleviate side effects should be monitored carefully, with blood pressures checked in the evening to assure control throughout the day. Dosing schedules must be individualized and single-dose therapy must not be assumed to be unequivocally effective.

Propranolol. Currently several other antihypertensive agents have undergone trials of efficacy with decreased frequency administration schedules. Several current studies have shown propranolol (Inderal®) to be effective in lowering blood pressure when administered on a twice a day or even once a day schedule.[35, 36, 38] In a study by Wilson et al[36] on 11 hypertensive patients and Westerlund and Hanson[38] on 19 hypertensive patients, blood pressure control was maintained when patients previously controlled on a two or three times daily administration of propranolol were switched to once-a-day dosing. Preliminary results indicate that it is also possible to initiate propranolol treatment on a once daily schedule.[38]

This prolonged action indicates that effectiveness does not correlate directly with the plasma half-life of propranolol, which is around six hours. This may be due to the longer half-life of active metabolites or to saturation of the tissue with active drug which maintains effectiveness after blood concentrations have declined.[35]

Clonidine. Clonidine (Catapres®), a relatively new antihypertensive agent, is recommended by the manufacturer to be given two times a day. The mean half-life of clonidine has been reported to be 12.7 ± 7 hours, which implies it may be feasible to ad-

minister this drug less frequently. Jain [39] studied 12 patients with essential hypertension given a t.i.d. dose of clonidine initially and then given the total dose once daily at 8:00 p.m. with the once daily dose, blood fluctuations were much wider than they were during t.i.d. therapy with the greatest blood pressure readings occurring near the end of the dosing interval. Most patients preferred the once-a-day dosage regimen because of the lack of drowsiness during the day.

A major disadvantage of clonidine therapy is the mild to moderate drowsiness occurring throughout the day. The limited data presented here suggest some patients may be controlled on a twice a day dosing schedule, with a larger dose given at bedtime and a smaller dose before noon. This approach may improve compliance by limiting daytime drowsiness. Individualization of therapy is stressed when this or any new dosage regimen is utilized.

Hydralazine and Prazosin. Studies have shown that when used with a diuretic, hydralazine (Apresoline®) is effective and safe when administered to hypertensive patients in a twice daily dosage schedule.[40, 58-60] The data from a large multicenter study of 194 patients suggested a significant number of patients receiving hydralazine q.i.d. may be treated with comparable efficacy on a b.i.d. dosage regimen. The only major difference appeared to be a slightly greater incidence of dizziness or lightheadedness on the b.i.d. schedule.[40] The mechanism for this long action of hydralazine is not known since the half-life is less than three hours. Studies in rodents have shown that hydralazine is rapidly taken up and retained by the arterial blood vessels and then released slowly, thus producing a longer duration of action.[59]

Prazosin (Minipres®), another vasodilation drug, has also been effective in several studies when administered on a b.i.d. schedule, rather than the recommended t.i.d. schedule.[41, 42]

Anti-Inflammatory and Analgesic Agents

Patients with rheumatic disorders present the practitioner with many problems only one of which may be noncompliance with a prescribed regimen. Besides a drug that is safe and effective, arthritic patients prefer one that can be administered with less frequency. When a questionnaire about which features of antirheumatic medications were considered desirable was administered to 200 rheumatic outpatients, one of the most frequently desired attributes was that of once daily administration.[43]

Salicylates. In comparing the various salicylate products currently on the market, only choline magnesium trisalicylate (Trilisate®) is approved for twice a day dosage. The half-life of this drug is 9-17 hours which permits maintenance of adequate blood levels throughout a 12 hour interval. A study reported by the manufacturer revealed that steady-state blood levels averaged 30 mg/100 ml peak and 15 mg/100 ml trough in patients consuming three 500 mg tablets twice a day.[44] This dosage interval may improve compliance in selected patients who cannot remember or display defiance about taking aspirin tablets every four to six hours. This drug is significantly more expensive than aspirin ($10.00/100 wholesale) which may be the overriding factor precluding its use.

Non-Steroidal Anti-inflammatory Agents. Since 1974, four non-steroidal anti-inflammatory drugs have been marketed in the U. S.; (ibuprofen (Motrin®), tolmetin (Tolectin®), fenoprofen (Nalfon®), and naproxen (Naprosyn®). The efficacy and side effects of these drugs are similar, with the outstanding difference being the dosage intervals. Only naproxen has a sufficiently long half-life (13.5) hours) to be approved for twice a day dosing. In a recently reported multicenter comparison of naproxen (variable dose frequency) vs indomethacin in a double blind, cross-over fashion to 132 patients with rheumatoid arthritis, the efficacy of a single dose of naproxen was comparable to that of twice daily dosage.[45] This limited evidence suggests that selected patients may warrant a trial of once daily administration of naproxen, with the possible advantages of diminished morning stiffness and greater patient compliance.

Anti-infective Drugs

Urinary Tract Anti-infectives. The duration of antimicrobial therapy commonly prescribed for treating urinary tract infections ranges from 5 to 21 days, with dosage administration scheduled three or four times a day. Currently there is convincing evidence that a short course of therapy[61] or single dose therapy with certain drugs is equally efficacious.[62-69]

A recent study by Bailey and Abbott[62] of 40 women with asymptomatic bacteriuria, cystitis or acute pyelonephritis and 20 children who were either asymptomatic or had cystitis showed equal improvement on sulfamethoxazole trimethoprim (Septra®, Bactrim®) when administered orally in either a single dose or a five to seven day course. Adults received a single dose of 0.48 gms of trimethoprim and 2.4 gms of sulfamethoxazole (6 tablets). Dosage for children varied with age. In both groups 17 of 20 (85 per cent) were cured. Seven of the 10 children who received the single dose were cured and eight of

the 10 treated with a seven day course were cured. With single dose administration side effects were absent and patients preferred taking their treatment in this manner.

Amoxicillin (Amoxil®, Larotid®) has also been shown to be effective in treating urinary tract infection in women and children when administered as a single oral dose (3 gms for adults and 100 mg/kg for children).[63] Side effects were absent.

Single dosing of parenteral drugs has been shown to be effective in certain types of urinary tract infections. A one time intramuscular dose of 2 gms cephaloridine (Loridine®),[65] 500 mg kanamycin (Kantrex®),[64] 160-200 mg tobramycin (Nebcin®),[68] or 160 mg gentamicin (Garamycin®)[69] has been successful in treating urinary tract infections. This may allow many patients to receive treatment in an ambulatory setting, eliminates the discomfort of multiple daily injections, and reduces the amount of nursing care and expensive supplies.[68]

Single-dose treatment with certain drugs appears to be successful in resolving most urinary tract infections in general practice, especially those presenting as cystitis or asymptomatic bacteriuria. The cost of amoxicillin and trimethoprim/sulfamethoxazole is high and thus a great savings is possible when utilizing single-dose therapy with these drugs. Compliance should also be increased since many patients stop treatment once the dysuria ceases. This dosage regimen is not recommended if the patient is severely ill with acute pyelonephritis or has a known urinary tract abnormality.[62]

Tetracycline. Shigella is a common disease in which several antibiotics are effective in eradicating clinical symptoms and fecal shedding. Ampicillin, tetracycline, or chloramphenicol is usually recommended to be administered several times a day for 5-7 days. Several studies have shown a single dose (2.5 gms) of tetracycline hydrochloride effective in the treatment of Shigella with clinical improvement and bacteriologic eradication of the organism from the stool within 48 hours of therapy.[70, 71] The low cost and effectiveness makes this therapy ideal for many patients. Single dose treatment with ampicillin or cephalexin has not resulted in adequate bacteriologic response.[72]

Metronidazole. Metronidazole (Flagyl®) has been the drug of choice for Trichomonas infections for many years. The FDA-approved dose is currently 250 mg three times a day for seven days for both men and women. Although the *in vitro* trichomonacidal activity of this drug is excellent, in clinical situations it is often found that the cure rate, both symptomatically and bacteriologically, is considerably less than desired. This may be due to failure to take the drug as prescribed, reinfection from a sexual partner, or drug failure due to poor absorption or inactivation.[52] Whenever possible, it is advantageous to treat sexually transmitted diseases with one-dose treatment. If carried out under observation this ensures intake of the drug in the correct dose, enables treatment of both partners, especially the partner who is asymptomatic and reluctant to take the drug, and renders the patients non-infective in the shortest possible time.[54] In the past several years studies attesting to the efficacy of a single dose of metronidazole have been published.[52-57] Most investigators have used a single 2 gm dose.

A recent study[53] of 203 females with symptomatic Trichomonas given a single 2 gm dose of metronidazole along with 2 gm to each of their sexual partners revealed a 95 per cent adjusted cure rate. No severe side effects were reported in the men or women, and in general, were no more frequent than with the extended therapy. However 2 per cent of the women vomited within 12 hours after the medication was consumed; but were still cured. Side effects in other studies have been reported to be as high as 80 per cent when a single 2 gm dose was used.[54] Nausea was frequently reported.

The use of a single 2 gm dose (8 tablets) of metronidazole has been shown to be safe, effective, and fairly well tolerated. Patients receiving this therapy should be warned to abstain from alcohol for 48 hours after administration due to the possibility of an antabuse-like reaction. The physician should also stress the importance of treating each sexual partner in order to reduce reinfection. Since the cost of flagyl to the pharmacist is approximately 27¢ per tablet the cost savings to the patient or third-parties can be substantial with this dosage schedule. The most common side effects consisting of nausea, abdominal discomfort, and bad taste should also be more tolerable with the decreased length of treatment.

Miscellaneous Agents

Topical Corticosteroids. It has been customary to have patients apply topical corticosteroids three or four times a day. These recommendations appear reasonable, but unfortunately few pharmacokinetic data from clinical trials are available to support this recommendation.

Vickers[46] in 1963 demonstrated that steroids were held in a reservoir underneath the horny layer, and that if the area was re-occluded, more steroid could be released into the underlying dermis. Subsequent

studies utilizing radioactive methodology proved that fluorinated steroids could remain beneath the horny layer for as long as 41 days.[47]

Conditions for which once-a-day dosing appear to be adequate include occlusive therapy with plastic or corticosteroid tape and in most cases of seborrheic dermatitis of the scalp and face.[48] Pruritus ani may be relieved by as little as once weekly application of a corticosteroid cream.[49] Empirically, it may be prudent to recommend that when the patients' lesions respond, the frequency of application should be decreased to the least number that will control the disease process.[48]

Allopurinol. Since the introduction of allopurinol (Zyloprim®) in the mid-1960's it has gained widespread acceptance in the treatment of gout and other hyperuricemic states.

Until 1973 the manufacturer of allopurinol stated that "divided doses are advisable because of the short half-life of the drug." In 1973 this statement was dropped from the package insert and replaced in 1974 with the recommendation that appropriate dosage may be administered in divided doses or as a single equivalent with the 300 mg tablet.

Why were the above administration recommendations changed? When allopurinol first became available it was known that the plasma half-life was less than two hours. Based on this information, a divided dosage schedule was recommended. However, a large portion of allopurinol was found to be metabolized to oxypurinol, which is also an inhibitor of xanthine oxidase, but with a half-life of 18-30 hours.[50] With this information, single daily dose studies were performed which attested to the efficacy of this regimen.[50, 51]

Physicians unaware of this change who are not utilizing the single dose regimen may be decreasing patient compliance and increasing drug cost. Gastrointestinal problems are seldom a problem on the single dosing schedule, but may necessitate a divided dose schedule.

Conclusion

The physician who is familiar with the current concepts of drug dosing has a greater armamentarium available for improving compliance and decreasing health care costs. In discussing frequency of administration, generalizations are hard to make and every patient must be evaluated on an individual basis. Studies are constantly appearing in the literature espousing the efficacy of drugs administered at increased dosage time intervals. It is prudent for the physician to keep abreast of this information, evaluate it carefully, and utilize it wisely as the situation demands. ★★★

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DID YOU KNOW?

• American workers were off the job an average of 3.7 days in 1976 because of some acute health condition.

—Health Insurance Institute

Radiologic Seminar CLXXXIV: Brenner Tumor of the Ovary—Ultrasound Findings

CHARLES O. WILLIAMS, M.D.
Greenwood, Mississippi

BRENNER TUMORS of the ovary occur most frequently in post-menopausal women. In contrast with other ovarian tumors, Brenner tumors usually grow slowly. There are no characteristic signs or symptoms. The origin of the tumor is uncertain. With rare exceptions, Brenner tumors are benign.

Case Report

The patient examined is a 48-year-old black female. She presented to her local physician with the chief complaints of headache, dizziness, pedal edema, abdominal pain and abdominal swelling. The patient dated the onset of her signs and symptoms six to eight months prior to being seen and these had been progressive over this period of time. The patient's menstrual history was unremarkable with normal menses occurring at the time of admission. Physical examination revealed a well developed, acutely and chronically ill black female. Pertinent physical findings were: blood pressure 190/120, facial puffiness, 4 plus bilateral pitting pedal edema and a large firm mass extending from the pelvis into the upper abdomen. The pelvic examination confirmed the mass and the examiner was unable to separate the mass from the patient's uterus. Pertinent laboratory findings were: WBC 9,000 with normal differential count, hemoglobin 8.6 gm per cent, hematocrit 30.7 per cent, urinalysis within normal limits, SMA12/60 within normal limits except total protein 5.6 gms per cent, and LDH 300 mU/ml. A plain film of the patient's abdomen (KUB) demonstrated a large mass apparently arising from the pelvis and extending into the abdomen. Ascites was suggested. A chest film revealed a small left pleural effusion. An I.V. Pyelogram was performed and the 15 minute film from this study is shown in Figure 1. No intrinsic abnormality of the urinary tract was identified. The mass is demonstrated by displaced gas shadows (black arrows) in the abdomen and extrinsic pressure (white arrows) on the urinary bladder in the pelvis. No calcification was detected within the mass.

Ultrasound examination of the patient's abdomen and pelvis was performed with serial, longitudinal, and transverse scans being obtained. A typical longitudinal scan is shown in Figure 2. As shown, the patient's head (H) is to the left. The central vertical marker (U) locates the umbilicus and the vertical marker (S) the symphysis pubis. The large mass with both pelvic and abdominal components is well defined (white arrows). The mass demonstrates multi-



Figure 1. Fifteen minute film from I.V. Pyelogram.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Greenwood Leflore Hospital, Greenwood, MS



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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VASODILAN®

(ISOXSUPRINE HCl)

20-mg tablets

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Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphtol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.

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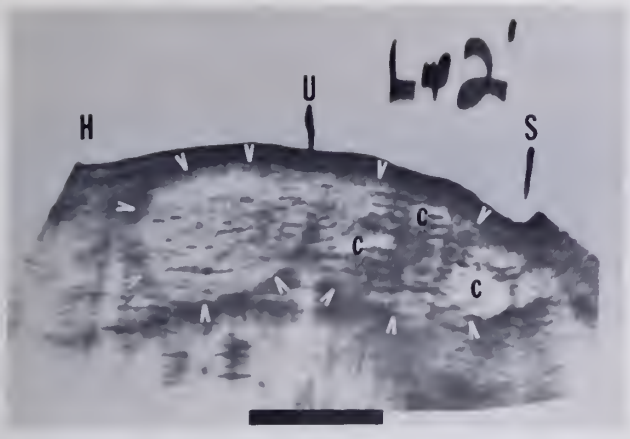


Figure 2. Longitudinal ultrasound scan taken 2 cms to the right of the midline. The patient is supine with her head (H) to the reader's left.

ple internal echoes and the transmission pattern is characteristic of a solid mass. There are, however, cystic areas (C) within the mass. Note the narrow waist the mass demonstrates at the level of the umbilicus. The patient's uterus was never clearly defined.

A specific diagnosis was not made but it was felt that the mass most likely was ovarian in origin. A laparotomy was performed and a large mass arising from the right ovary was resected. The mass was adherent to the transverse colon, omentum, and urinary bladder. The uterus demonstrated no abnormality. The mass weighed 3,000 gms and measured 28 by 17 by 12 cms. The gross specimen is shown in Figure 3. The abdominal component of the mass is marked A and the pelvic component is marked P. Note the dumb-bell shape and how well this correlates with the ultrasound findings. On cut sections the mass was predominantly solid but demonstrated several areas of hemorrhagic necrosis and cystic degeneration. The microscopic diagnosis was Brenner tumor of the ovary, benign.

The patient's hypertension is being managed medically and her postoperative recovery was uneventful.



Figure 3. Gross surgical specimen with abdominal (A) and pelvic (P) components labeled.

Summary

The usefulness of diagnostic ultrasound in the evaluation of abdominal and pelvic masses is well established. Even when a specific diagnosis cannot be made, as in this case, much useful information can be gained especially in pre-operative evaluation and planning. ★★★

1304 Hemingway Street (38930)

A man may not be what he thinks he is; but what he thinks, he is.



The President Speaking

CPE—How Much of a Good Thing Is a Good Thing?

CARL G. EVERS, M.D.
Jackson, Mississippi

THE ABOVE question, paraphrased from a remark attributed to Mae West, to the effect that "Too much of a good thing is a good thing," is perhaps pertinent to the current situation in continuing physician education (CPE).

In view of recent trends by various groups toward mandating some level of CPE, the question to be examined is not whether CPE is good, but rather how good is what for whom? Certainly CPE is good for its promoters who organize and conduct programs and publish instructional materials. Some are real entrepreneurs, promoting CPE courses in exotic places at exotic prices and for them the Mae West remark is perhaps particularly valid.

Most physicians agree that one cannot get too much continuing education, if it is pertinent and this is the real key to the future success of CPE. From experience thus far, several points have evolved with which there is general agreement by physicians involved in CPE. The first is that it is difficult if not impossible to evaluate the effectiveness of CPE by any precise measure. It is also clear that the current concept of requiring a certain fixed number of CPE hours is not adequate. Rather, CPE must be related to the assessment of an individual physician's practice profile or to state it another way, the assessment of physician competence.

Physicians concerned with the "nuts and bolts" of CPE generally agree that there are three dimensions to defining competence. The first of these, the cornerstone, is knowledge, i.e. knowledge of *pertinent* factual information. This area can be measured, but the question as to how to determine when a physician falls below what is considered minimum competence remains.

A second dimension is that of ability. This includes communicative skills, dealing with physician-patient interaction in securing data, enlisting patient cooperation, and assuring patient confidence and satisfaction. Implied are skills in interviewing and performing physical examinations. Also included, and very difficult to measure, are self-discipline, work habits and professional attitudes.

A third dimension is the ill defined area of clinical judgment, i.e. the ability to apply appropriate knowledge and skills at the right time in patient management. Computer assisted simulations of patient encounters are quite good, but the question again arises, when does a physician fall below an acceptable level of competence?

It is almost certain that increasing efforts to assure physician competence will be forthcoming. It is now a public as well as professional goal even though the proper blend of public and professional interest in reaching the goal is undecided. Our efforts are based on the position that physicians are best able to assess ability and clinical judgment within the scope of an individual's practice.

The dimension of knowledge is being assessed as a requirement for continued certification by many specialty boards. The dimensions of ability and clinical judgment are being assessed through medical audits, PSROs, etc. These reveal that the areas of greatest concern are in the documentation of basic history and physical examination data to arrive at patient management. They also show that physicians more often encounter management problems in the areas of overlap with general patient care, not in the area of specialty or expertise. These problem areas can perhaps be more effectively dealt with by CPE activities at the local community hospital level rather than on any state or national level. This might be considered an incentive for renewed efforts of the MSMA Council on Medical Education to encourage, support and approve community hospitals' CPE programs.

The means of financing CPE activities is also a very complex issue. To be effective and to assure success, adequate funding must be available.

These and other CPE issues will be examined at an upcoming Sixth Biennial Conference on Continuing Medical Education for State Medical Associations and Specialty Societies, sponsored by the American Medical Association. In summary, mechanisms to provide CPE and to assure professional competence have increasing significance for both the medical profession and the public. Effective CPE must be related to an assessment of physician competence. The medical profession can best make this assessment and is attempting to do so. ★★★

EDITORIALS

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Poisonous Snakebite

Summer in the South is the time of barefoot children and outdoor play and, unfortunately, also the time most likely to be bitten by a poisonous snake.

There are only four species of poisonous snakes in the United States; i.e., the rattlesnake, the water moccasin, the copperhead, and the coral snake. In Mississippi, the coral snake is very rare, found occasionally along the coastal areas. The other three types are commonly found throughout the state. The poisonous pit vipers are usually easily identified from a distance by their triangular head. Closer inspection reveals the two fangs in the upper jaw, slit pupils, and the pits below the eyes. Obviously, this "close" inspection should be done only on a very dead snake, unless one is well versed in handling poisonous reptiles.

The characteristic wounds caused by the pit viper usually consist of two fang punctures surrounded by an area of edema, ecchymosis, and petechial hemorrhage. Pain and swelling may be severe. The severity of the bite may be graded from 0 to IV, with 0 showing no local or systemic signs, while Grade IV is characterized by severe pain with rapid swelling and ecchymosis. There may be immediate signs of systemic involvement with bleeding diastasis. For treatment purposes, the patients may be divided into two types: nontoxic and toxic.

Nontoxic bites require little, if any, local or symptomatic treatment. The fang holes may be excised if seen in less than one hour. Suction aspiration is of value only if done immediately after the bite. Venous tourniquets should not be used. A string tourniquet above and below the wound to block lymphatic spread may aid in containing diffusion of the toxin. The patient should be observed for toxic reaction and treated with tetanus toxoid and antibiotics. Antivenin, made from horse serum, should never be used in nontoxic patients. The danger of allergic reaction far outweighs any therapeutic value.

The treatment of toxic patients with pit viper envenomization centers around the adequate and early administration of intravenous antivenin, together with supportive measures of intravenous fluids and respiratory support. Hypotension and bleeding diastasis may require treatment with fibrinogen, procoagulants, and fresh whole blood. Large doses of cortisone have been advocated by some but the value of this treatment has not been conclusively proven.

The morality rate of pit viper envenomization in the United States is approximately one per one thousand bites. Many times patients showing no systemic toxic symptoms are over-treated to the extent that the cure is worse than the disease.

Physicians likely to be called upon to treat poisonous snakebite should learn to identify poisonous from nonpoisonous snakes and to recognize the fang wounds of pit vipers. Treatment should be tailored to fit the patient's symptoms, reserving antivenin for those with systemic toxic reaction.

GEORGE H. MARTIN, M.D.
Associate Editor
Vicksburg, MS

Medico-Legal Brief

Effect of Refilling Drug Prescription on Physician-Patient Relationship

Summary judgment was precluded in a malpractice suit where there was an issue as to whether a physician-patient relationship was terminated with regard to a patient who refilled a prescription within a year of bringing suit, a federal trial court in Ohio ruled.

In March 1972, the patient visited a clinic because of red bumps and swellings on her legs and ankles. A physician diagnosed erythema nodosum and gave her a prescription for prednisone.

Over a period of two years, the patient saw the physician about six times and he continued to prescribe prednisone. When she next visited the clinic,

MEDICO-LEGAL / Continued

on Oct. 9, 1974, a second physician saw her. Six months later, when she was planning to leave the state, the second physician advised her to take the drug for flare-ups. Two weeks after that, a third physician at the clinic advised her to discontinue the drug except for flare-ups.

The patient's mother made another appointment for her, in May 1975, when she was returning home, but she broke the appointment. In February 1976, she filled one of the prescriptions that the first physician had given her.

On Oct. 15, 1976, the patient filed a suit for malpractice against the clinic and the first two physicians, alleging malpractice in that she had developed osteoporosis as a result of taking prednisone. She contended that the physicians had failed to warn her of this possible side-effect.

The clinic and physicians moved for summary judgment, contending that the suit was barred by the one-year statute of limitations. The patient contended that where she refilled her prescription for the drug in February 1976, and took it under the orders of the clinic physicians, she was still under their care and the physician-patient relationship had not been severed within one year prior to filing suit.

Finding that there was a genuine question of fact as to the existence of a physician-patient relationship, which must be determined at trial, the court denied the clinic's motion for summary judgment. — *Kraus v. Cleveland Clinic*, 442 F.Supp. 310 (D.C., Ohio, Nov. 29, 1977)

PERSONALS

THOMAS M. BLAKE of Jackson and UMC discussed the role of the computer in electrocardiography with hospital staff in Raleigh.

D. L. BOLTON announces his association with KENNETH R. W. WARREN of Picayune for family practice at 906 Sixth Avenue.

ROBERT L. BUCKLEY, JR., of Columbus announces the association of JACOB SKIWSKI for the practice of pediatrics at 2461 5th Street South.

C. E. CATCHINGS and JENNINGS OWENS of Woodville announce the association of DAVID B. MCGRAW for family practice on First South Street.

FRANCIS R. CONN of Hattiesburg announces his return to the practice of orthopedic surgery and the relocation of Hattiesburg Bone and Joint Clinic, P.A. to 108 South 28th Avenue.

THOMAS S. GLASGOW, formerly of Grenada, announces the relocation of his offices for family practice to 2169 South Lamar in Oxford. He will be associated with JAMES O. GILMORE.

WILLIAM R. FELLOWS announces the opening of his office for the practice of internal medicine at Coastal Medical Center in Gateway Executive Park in Biloxi.

Drs. KIRK, CALDWELL, HILBUN and HUTCHINSON of Tupelo announce the association of JIMMY L. HAMILTON with the Surgery Clinic of Tupelo, P.A. for the practice of general, thoracic and vascular surgery at 607 Garfield Street.

THOMAS FINLEY HEWES and WILLIAM L. SEIDENSTICKER announce the opening of the Gulf Coast Orthopaedic Clinic in the Omega Medical Arts Center at 1500 45th Avenue in Gulfport.

The Jackson Clinic for Women, P.A. announces the association of MERCER LEE for the practice of obstetrics and gynecology at 1030 North Flowood Drive in Jackson.

CAROLE MANGREM and PEGGY J. WELLS announce the opening of their office for the practice of general pediatrics at 1742 State Street in Clarksdale.

THOMAS MCFARLAND announces the opening of his office for family practice in Lumberton.

FRANCIS S. MORRISON of Jackson and UMC gave a lecture on the relative safety of assurance and volunteer blood donors to the Council of Community Blood Centers meeting in Kansas City.

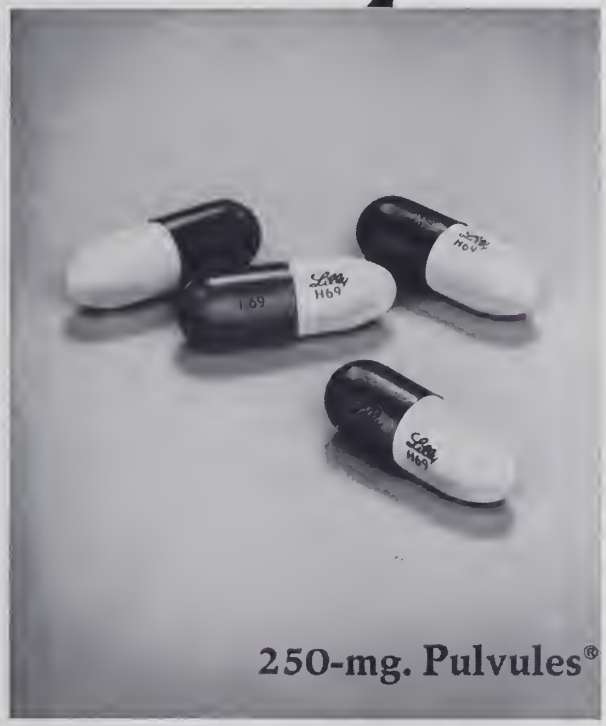
NORMAN C. NELSON of Jackson and UMC spoke at the quarterly meeting of the Singing River Medical Society in Pascagoula.

JACK SENTER and LEON RATLIFF of Belmont announce the association of DONALD RATLIFF for the family practice of medicine in the Senter-Ratliff Clinic.

GERALD ROBERTSON of Hattiesburg took part in a recent Baptist medical and evangelical mission to Honduras.

RICHARD YELVERTON of Jackson piloted a high performance sail plane as part of the antique and modern airplane show at the Jackson Symphony Orchestra's annual pops concert at the Ross Barnett Reservoir.

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"...Sleep that knits up the ravell'd sleave of care..."

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And, in anxiety/depression, Adapin® (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime[1] Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information
ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, nor on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 25 mg t.i.d. Increase or decrease the dosage according to individual response. Daily dosage, up to 150 mg may be taken at bedtime without loss of effectiveness. Usual optimum daily dosage is 75 mg to 150 mg per day not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg, 50 mg and 100 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.



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POSTGRADUATE CALENDAR

Sept. 21-22, 1978
ALLERGY FOR THE GENERALIST
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine and the University Medical Center Division of Continuing Health Professional Education; the University of Tennessee Center for the Health Sciences College of Medicine; and the Vanderbilt University School of Medicine.

Coordinator: Bernard Booth, M.D., clinical associate professor of medicine, University of Mississippi School of Medicine.

This two-day course is the second in a cooperative series hosted by the sponsor schools. Internists, pediatricians and family physicians who care for patients with allergic problems are invited. Major emphasis is diagnosis and management of allergic disorders. Fee: $85.00. Credit: 16 contact hours, 1.6 CEU, Category 1, AMA; AAFP.

Oct. 6-7, 1978
ADVANCED CARDIAC LIFE SUPPORT
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Anesthesiology; the University of Mississippi School of Nursing; the University of Mississippi School of Dentistry Department of Oral and Maxillofacial Surgery; and the Medical Center Division of Continuing Health Professional Education in cooperation with the American Heart Association, Mississippi Affiliate.

Coordinator: Thomas J. Herrin, M.D., associate professor of anesthesiology, University of Mississippi School of Medicine.

Open to physicians and registered nurses who have been certified by the American Heart Association in basic life support, this course will be taught by faculty qualified by the American Heart Association as advanced cardiac life support instructors. The two-day program is designed for physicians and nurses engaged in advanced cardiac life support on a daily basis. The course is limited to 48 participants; registration will close Sept. 22. Fee: $75.00. Credit: 16 contact hours, 1.6 CEU; Category 1, AMA; AAFP.

Oct. 9-13, 1978
PRACTICE OF ELECTROCARDIOGRAPHY
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine and the University Medical Center Division of Continuing Health Professional Education.

Coordinator: Thomas M. Blake, professor of medicine and chief of the Cardiology Division and of Electrocardiography, University of Mississippi School of Medicine.

This five-day course is for physicians who use electrocardiograms in their practice. Fee: $150.00. Credit: 40 contact hours, 4 CEU, Category 1, AMA; AAFP credit applied for.

FUTURE CALENDAR

Oct. 26-27, 1978
ARTHRITIS SEMINAR
University Medical Center, Jackson

Nov. 10, 1978
UPDATE: PITUITARY SYMPOSIUM
University Medical Center, Jackson

Nov. 10-12, 1978
FAMILY PRACTICE REVIEW
University Medical Center, Jackson

Dec. 2, 1978
DIAGNOSIS, TREATMENT AND REHABILITATION OF PATIENTS WITH UPPER ARM PROBLEMS
Methodist Rehabilitation Center, Jackson

All continuing education correspondence should be addressed to: Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson 39216.

NEW MEMBERS

CROWELL, JACK W., Ruleville. Born Itta Bena, MS, May 2, 1926; M.D., University of Mississippi School of Medicine, Jackson, 1977; elected by Delta Medical Society.

FUNDERBURG, JAMES C., Natchez. Born Tiffin, OH, Mar. 31, 1944; M.D., Ohio State University School of Medicine, Columbus, 1971; interned Fitzsimons Army Medical Center, Denver, CO, one year; otolaryngology residency, same, 1971-74; elected by Homochitto Valley Medical Society.

NEW MEMBERS / Continued

HOBB, MILTON D., Oxford. Born Cambridge, MA, Nov. 17, 1948; M.D., University of Alabama School of Medicine, Birmingham, 1974; interned Charlotte Memorial Hospital, Charlotte, NC, one year; internal medicine residency, University of South Alabama, Mobile, 1975-76; internal medicine residency, Charlotte Memorial Hospital, Charlotte, NC, 1976-77; elected by North Mississippi Medical Society.

PETTIT, PAUL N., JR., Natchez. Born Memphis, TN, Sept. 26, 1942; M.D., University of Arkansas School of Medicine, Little Rock, 1971; interned Tulane, New Orleans, LA, one year; general surgery residency, Emory, Grady, VA, and University Hospitals, Atlanta, GA, 1974-75; ENT residency, Ochsner, Charity, and EENT Hospitals, New Orleans, 1975-78; elected by Homochitto Valley Medical Society.

VILARDI, PAUL, Houston. Born Paterson, NJ, June 17, 1946; M.D., State University of New York College of Medicine, Brooklyn, NY, 1972; interned Mercy Hospital, San Diego, CA, one year; orthopaedic surgery residency, State University of New York Hospital, Buffalo, 1973-77; elected by Northeast Mississippi Medical Society.

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Review A Book

The following books have been received by the MSMA Headquarters Office. Medical readers (members of MSMA) interested in reviewing any of these volumes should address their requests to Editor, THE JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION, P.O. Box 5229, Jackson 39216. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to the JOURNAL a review for publication.

Mealtime Manual for People with Disabilities and the Aging. Prepared by Institute of Rehabilitation Medicine, New York University Medical Center and Campbell Soup Company, 1978. $3.25.

The Health Practitioner in Family Relationships. By Eugenia L. Gullick, Ph.D., and Steven F. Peed, Ph.D. Westport, CT: Technomic Publishing Co., 1978. $15.00.

Current Obstetric and Gynecologic Diagnosis and Treatment. 2nd edition. By Ralph C. Benson, M.D. Los Altos: Lange Medical Publications, 1978. $18.00.

General Urology. 9th edition. By Donald R. Smith, M.D. Los Altos: Lange Medical Publications, 1978. $14.50.

Dr. A. W. Conerly Named to Respiratory Therapy Board

Dr. A. Wallace Conerly, assistant professor of medicine and medical director of respiratory therapy at the University of Mississippi Medical Center, has been named to the National Board of Respiratory Therapy.

He is the American Thoracic Society's appointee to the board of trustees of the national organization.

Dr. Conerly will serve a four-year term on the board. The Tylertown native also serves on the oral and written examination and admissions committees of the organization.

MSMA Board Considers Full Agenda at Regular Summer Meeting in Tupelo

MSMA's Board of Trustees held its regular summer meeting in Tupelo, Aug. 3-4, and acted on a full agenda of business to include referrals from the House of Delegates, certificate-of-need legislation and "second surgical opinion" programs.

In implementing actions of the MSMA House of Delegates at the recent 110th Annual Session, the Board appointed Dr. Ellis Moffitt of Jackson to chair a committee to establish an association sponsored rehabilitation program for alcohol and drug addicted physicians. The Board also reviewed plans to conduct an independent public opinion poll on health care and to formulate an MSMA position paper on the state's health needs.

In another House of Delegates referral dealing with physicians' assistants, the Board noted and restated its support of Mississippi Law requiring physicians' medical assistance personnel to be under direct and immediate supervision of their physician employer.

The Board also reviewed the status of certificate-of-need legislation in Mississippi based on an inquiry from a member of the Senate Public Health Committee who pointed out that the Legislature would be called on to enact a certificate-of-need law during its 1979 session. It was the unanimous decision of the Board that the association should support a certificate-of-need law meeting minimum federal requirements for such legislation recognizing that certificate-of-need was still an unproven process with respect to its stated goal of medical cost containment.

On a matter related to certificate-of-need legislation, the Board also went on record in support of legislation placing the State Health Planning and Development Agency in the Mississippi State Board of Health and recognizing that the director of such agency would be appointed by the State Health Officer on advice of the Statewide Health Coordinating Council which would be independent of the Mississippi State Board of Health.

The Board additionally considered so-called "second opinion programs" sponsored by third party payors such as government and health insurance companies and adopted a statement in this regard which was distributed to the membership in the "MSMA Bluesheet." The statement generally noted the medical profession's long held practice of seeking consultation in difficult cases or when requested by the patient and stated the association's opposition to mandatory, closed panel, "second opinion" programs conducted by any third party payor.

In other matters the Board heard a report from the association's delegates to the American Medical Association. The report noted that the AMA had gone on record in support of MSMA's position to label alcoholic beverages as "harmful to one's health" and had referred an MSMA resolution in opposition to NHI to the AMA Board of Trustees for further consideration. The Board reviewed various legal matters before the association and heard a status report on operations of the Mississippi Medical Fraternal and Educational Society, the Mississippi Medical Political Action Committee and the Mississippi Foundation for Medical Care.

The status of home health care agencies in Mississippi was also reviewed by the Board and the Board acted to have the association support the Mississippi Foundation for Medical Care in its efforts to conduct medical review for third party payors such as Travelers' Medicare.

Blue Cross-Blue Shield Holds Claims Filing Workshops

Blue Cross and Blue Shield of Mississippi is sponsoring a series of workshops for physicians' office personnel designed to benefit those people involved in counseling patients and in the completion of claims for Blue Shield, Medicaid, and FEP.

The workshops, scheduled monthly from August through December, are held at the Blue Cross and Blue Shield Plan's new Service Center on Lakeland Drive East.

According to Bud Peters, director of Professional and Provider Relations, the August workshop was 100 per cent filled and the September workshop is now closed for applications.

"Physicians are urged to take advantage of this excellent opportunity for the training and development of personnel involved in the claim filing process," Peters said. "We recommend that new office personnel and insurance clerks, as well as any personnel who may have missed our April workshops, attend."

There is no registration fee for those attending and a complimentary luncheon will be provided.

Dates for future workshops are as follows: Oct. 12, Nov. 9, and Dec. 7. The workshops will begin at 9:00 a.m. and will conclude at approximately 2:00 p.m. A guided tour of the Service Center will be conducted at the conclusion of the workshops.

For further information, call Blue Cross and Blue Shield of Mississippi at 932-3704, Extension 252.

Pediatric Pulmonary Case Conference Is Scheduled

The fourth annual LAMAT Pediatric Pulmonary Case Conference, sponsored by Lung Associations and Thoracic Societies of Louisiana, Arkansas, Mississippi and Alabama will be held Friday and Saturday, Sept. 29-30, 1978, at the Camelot Inn, Little Rock, AR.

Dr. Suzanne Miller, assistant professor of pediatrics, University of Mississippi Medical Center, and Dr. W. Q. Cole of Jackson are serving as Mississippi's chairmen. Dr. Miller will also present a series of cases on Chronic Aspiration.

Dr. A. Joanne Gates, director of pediatrics, Children's Hospital, New Orleans, is conference chairman. Guest consultants are Dr. Alvin H. Felman, Gainesville, FL, Dr. Douglas Holsclaw, Philadelphia, PA, and Dr. Lynn Taussig, Tucson, AZ.

Six teams of physicians presenting topics of special interest on pulmonary cases include Dr. Rosalind S. Abernathy, Little Rock; Dr. Aram S. Hanissian and Dr. Webster Riggs, both of Memphis; Dr. Suzanne Miller; Dr. Robert Hopkins and Dr. Jack Reyes, both of New Orleans; Dr. Dana Brasfield and Dr. Grady Morgan, both of Birmingham; and a physician team from Texas.

LAMAT, providing postgraduate opportunities for physicians, is part of the medical and professional education program of workshops and seminars made possible by Christmas Seal donations, Memorial Gifts and other contributions to the Mississippi Lung Association and associations of participating states.

Accreditation applications have been made to the American Medical Association and the American Academy of Family Physicians. For more information, contact the Mississippi Thoracic Society and/or the Mississippi Lung Association, P.O. Box 9865, Jackson, MS 39206.

First Callender Memorial Scholarship Is Awarded



The first annual nursing scholarship honoring the late Dr. Claude G. Callender of Jackson has been awarded at the University of Mississippi Medical Center. Jean Marie Barhonovich of Biloxi, second from right, received the scholarship awarded to an incoming graduate student in nursing for superior academic achievement, an interest in maternal and infant nursing and a commitment to practice in Mississippi. Dr. Callender, who practiced in Jackson for 29 years, was clinical associate professor of obstetrics and gynecology at the Medical Center at the time of his death last year. He had served on the UMC clinical faculty since 1955. With Ms. Barhonovich are, from left, Dr. Edrie J. George, UMC School of Nursing dean, Mrs. Claude G. Callender, and Dr. Willamay Whitner, nursing school associate dean for graduate programs.

Mississippi Supreme Court Defines Practice of Medicine

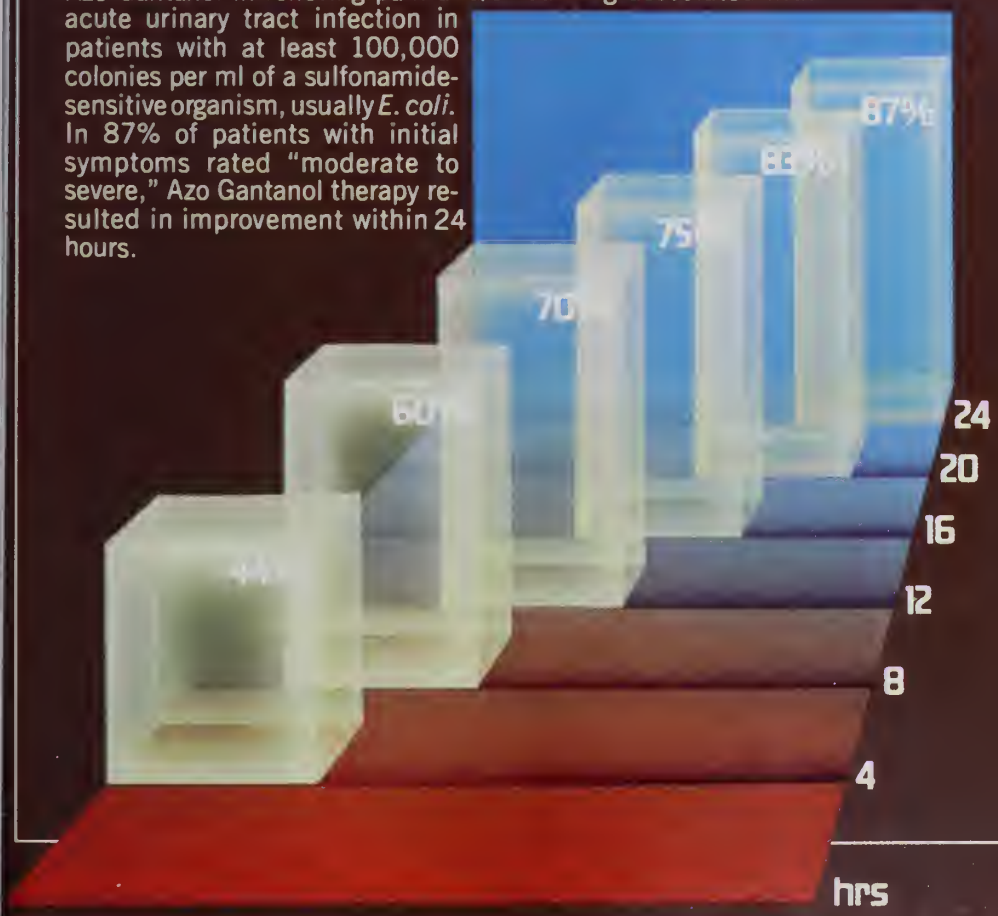
The Mississippi Supreme Court in a unanimous opinion has held that the use of microwave diathermy machines, ultrasonic devices, electric muscle stimulators and the prescribing, recommending or suggesting use of vitamins by a chiropractor constitutes the unlicensed practice of medicine and is illegal.

The court interpreted both the medical licensing act and the more recently enacted chiropractic licensing act in reaching its opinion in this regard which was in agreement with the association's lawsuit. The court further ruled, however, that the association could not seek an injunction against a chiropractor performing any of the illegal acts unless

Important data on the pain of acute cystitis:

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis;* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

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CĒPASTAT mouthwash/gargle (and spray) blends eugenol with phenol to provide a new authoritative flavor that tells your patients relief from discomfort is at hand.

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the association showed that no other legal remedy was available and the illegal acts resulted in irreparable harm.

Under Mississippi law legal remedy to seek an injunction against the illegal acts defined by the court, without the necessity of showing irreparable harm, rests with either the Mississippi State Board of Health, a county or district prosecuting attorney or the Chiropractic Licensing Board. Also, under Mississippi law the unlicensed practice of medicine is punishable by fine or imprisonment or both.

Winner of UMC Newborn Art Contest Is Announced



This photo by Les Potter of Jackson took "best in show" and photography division honors in the 1978 University of Mississippi Medical Center Newborn Center Art Contest. The picture shows Potter's wife, Marilyn, and son Ray with a nurse shortly after Ray's birth. Artists from all across Mississippi entered the third annual competition, cosponsored by the March of Dimes. The contest is designed to emphasize the importance of maternal and infant care.

HEW Announces Second Surgical Opinion Programs

Travelers Medicare of Mississippi will serve as the coordinator for a "second surgical opinion program" to be conducted by the Department of HEW in Mississippi and other states beginning around Sept. 1.

According to DHEW, television and mail publicity about the program will emphasize the value of "patient initiated second opinions" and give a telephone number for patients to call a "list holder" should they desire the name of physicians willing to render a "second opinion." Travelers will serve as the list holder.

Prior to initiation of the DHEW program, MSMA's largest component medical society announced plans to expand its current patient telephone referral service to include referrals to patients seeking second surgical opinions. According to Dr. Ellis Moffitt, an officer in Central Medical Society, and member of MSMA's Board of Trustees, the society viewed expansion of its patient referral service to include names of physician consultants as an extension of the medical profession's long held belief that "a physician should seek consultation upon request of the patient, in doubtful or difficult cases or whenever the quality of medical service would be enhanced thereby."

At its recent August meeting the MSMA Board of Trustees adopted the following policy statement in regard to "second surgical opinion programs" sponsored by third party payors such as government and health insurance companies.

"The medical profession has long believed and so stated in the 'Principles of Medical Ethics' that a physician should seek consultation upon request of the patient, in doubtful or difficult cases, or whenever the quality of medical service may be enhanced thereby. In this context physicians have historically made themselves available for consultation in their respective specialty areas and will continue to do so. Additionally, many state and county medical societies have provided 'public service' referral services to patients seeking a physician. In this light and in regard to so-called 'second surgical opinion' programs sponsored by third party payors, it is the view of the Mississippi State Medical Association that a decision regarding surgical intervention is a matter between the individual patient and his physician which should be unencumbered by actions of a third party payor. Specifically in this regard, the association opposes the concept of mandatory 'second surgical opinions' and the concept of requiring a patient to seek medical services from physicians chosen by a third party rather than the patient. Finally, it should be noted that over 18 million surgical procedures are performed annually in this country. Should a 'second surgical opinion' occur in each of these procedures there will be inconvenience in time to the patient and additional expenses in health services amounting to billions of dollars which will be paid by the public."

State Family Physicians Meet at Biloxi

Dr. Denis P. Burkitt, a London physician who acquired international fame for his discovery of a viral-caused lymphoma which bears his name and appears in most general and surgical textbooks as "Burkitt's Lymphoma," was the opening speaker when the Mississippi Academy of Family Physicians met in Biloxi July 12-15. Dr. Burkitt is also known for his study of the relationship between western disease and fiber depleted diets.

Other speakers for the three day meeting were: Dr. Wilfrid E. Shute of British Columbia who is presently recognized as the world's foremost authority on Vitamin E and has published two books, *Vitamin E for the Ailing Heart* and *The Complete Updated Vitamin E Book;* Dr. Terrence C. Kuske of the Medical College of Georgia who spoke on Diagnosis and Management of the Hyperlipidemias; Current Concepts in the Treatment of Chronic Obstructive Pulmonary Disease was discussed by Dr. Ben Branscomb of the University of Alabama; Dr. Gerald Plitman's subject was Current Status of Anti-Thrombotic and Anti-Coagulative Treatment with Dr. Jerome Ryan of Tulane University speaking on the Management of the Diabetic Patient. A Practice Management Seminar was conducted by Robert P. Levoy, director of Professional Practice Consultants in Great Neck, NY.

At the business session on Thursday, Dr. Edgar Johnson of Hattiesburg was named president-elect with Dr. J. Edward Hill of Hollandale, vice president; Dr. Ben E. Kitchens of Iuka, secretary-treasurer. The five district directors elected were: Drs. James C. Waites of Laurel, Hardy B. Woodbridge, Jr., of Jackson, Walter Johnston, Jr., of Vicksburg, John E. Powell of Houlka, and Malcolm Moore of Tupelo. The newly elected officers were installed at the banquet on Friday evening by retiring president, Dr. Ralph Brock of McComb. Dr. John Estess of Hollandale is the academy's new president.



Dr. Ralph Brock of McComb, presents the President's medallion to Dr. John Estess of Hollandale, new MAFP president.

Physician members and guests received up to 29 hours of prescribed credit by AAFP for attending all sessions, using auto-tutors, viewing film and the preceptor workshop.

Dr. Charles R. Jenkins of Laurel was the winner of the John B. Howell Memorial award which is given



Four of the five newly-elected directors are shown from left, Drs. James Waites of Laurel, Malcolm Moore of Tupelo, Walter Johnston of Vicksburg, and John Powell of Houlka.



Dr. Harold Brewer, left, of the Department of Family Medicine at UMC received the second place scientific award. Dr. John Hassell of Laurel presented the award to Dr. Brewer.

each year to the physician who has contributed most to family medicine in Mississippi.



Pete Mitchell, left, of the AAFP staff in Kansas City discusses CME hours with Dr. Edgar Johnson of Hattiesburg, center, MAFP president-elect, and Dr. J. Edward Hill of Hollandale, vice president.

Dr. Annyce Campbell and Dr. Thais Brown received plaques, Family Practice Textbook and a cash prize for the outstanding senior award. This award is given to the senior medical student (this year there was a tie) demonstrating excellence in performance and attainment of the written objectives during the family medicine rotation. The outstanding junior award was presented to James Glenn Peters.

U. S. Chamber of Commerce Examines Health Costs

The Chamber of Commerce of the United States has announced that a national action program on health will be initiated this fall to help employers contain health costs.

Health care costs must be held down at the community level, the Chamber said, because the job cannot be done by the federal government.

A recent report by the Chamber's Special Committee on the Nation's Health Care Needs pointed out that business must assume leadership because private firms last year paid about 40 per cent ($60 billion) of the nation's total health care bill through employee health insurance, occupational health service, taxes to support Medicare and Medicaid and through compliance with regulations for government health programs.

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Index to Advertisers

Air Force **8**
Burroughs Wellcome Co. 176D
Canton Exchange Bank **11**
Coca-Cola **11**
Citizens Bank and Trust Co. **14**
Dermik Laboratories ..... **second cover**
Disability Determination Services **15**
Harreld Chevrolet-Oldsmobile **16**
Hill Crest Hospital **12**
Eli Lilly and Co. 172A
Mead Johnson Laboratories 168A, 168B
Mississippi Stationery Co. **17**
Parke Davis and Co. **18**
Pennwalt Corp. 172B, 172C
Premier Printing Co. 174
Richardson-Merrell, Inc. 176C
Riverside Hospital **3**
Roche Laboratories .. **6, 7,** 176A, **third and fourth covers**
Roerig and Co. **10, 10A**
Signature Loans **19**
Smith Kline and French 176B
E. R. Squibb and Sons, Inc. **14A, 14B**
The Upjohn Co. 172D
Thomas Yates and Co. **4**

IN CONCLUSION

Long-time wearers of contact lenses should, perhaps, put them aside for some months every few years, says a research report in the Archives of Ophthalmology. The problem, says Dr. Michel Millodot of the University of Wales, Cardiff, is that the cornea loses sensitivity under constant wearing of hard contact lenses. This places these persons at greater risk of having an infection occur without their being aware of it, he points out. The Welsh study found that sensitivity returns to normal when the lenses are put aside.

At a recent meeting of the American Academy of Orthopedic Surgeons, a midwest orthopod called trampolining one of the most dangerous sports in the world. He reported 34 cases of paralysis and three deaths and also said he was successful in banning competitive trampoline events at 35 high schools in Indiana. Trampolining is still required as part of the physical education program in many schools. Physicians might help alert administrators to the potential danger of this sport and of the tragedy of a teen-aged quadriplegic.

Dismal results came from a General Accounting Office survey of 112 HEW operated neighborhood health centers in "medically underserved" designated areas. This $200 million program is afflicted with obesity, maldistribution, high cost, waste and failure to emphasize preventive medicine (which it was supposed to do). The majority of patients use the centers for sick calls, ignoring preventive medicine tries, said GAO which estimates only 10% of the 112 centers achieve HEW standards, a possible waste of $4.2 million.

U.S. Supreme Court held that insurance companies can be charged with federal antitrust violations for alleged agreements to refuse to sell malpractice insurance to doctors. The court voted 7-2 to affirm a lower court ruling that seven Rhode Island doctors and six patients could proceed with a suit against St. Paul Fire and Marine and three other companies. The plaintiffs allege St. Paul conspired with three other insurance companies in 1975 to fix the terms and conditions of medical malpractice insurance in Rhode Island.

Medical care costs increased nearly 10% last year, reports Health Insurance Institute. Actual increase in the 1977 Consumer Price Index for all medical care items was 9.6%. This was virtually the same as the 1976 increases--9.5%--but it was nearly two and a half percentage points less than in 1975. The recent slackening in health care cost inflation is seen by looking at individual components. For example, semiprivate hospital room rates rose 11.5% last year, in contrast to 13.8 in 1976 and 17.2 in 1975. Physicians' fees last year rose 9.3%.

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For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.



Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older.

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Nutley, New Jersey 07110

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Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

October 1978

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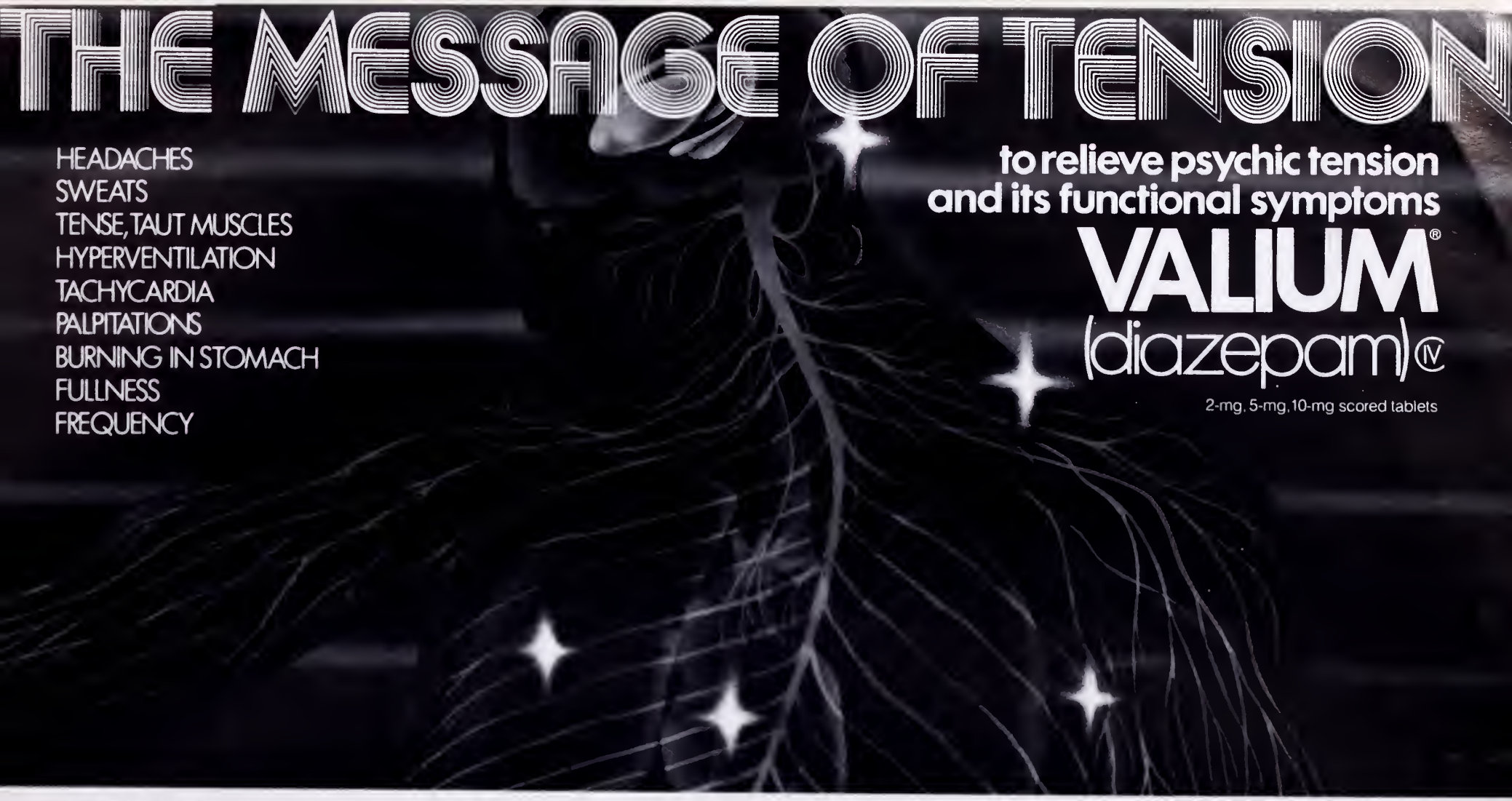


Contents:

Definitive Correction of Congenital Heart Disease in Infancy

Clinical and Laboratory Evaluation of Malabsorption

Subcapsular Hematoma of the Liver: A Case Repor



VALIUM® (diazepam)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors, psychoneurotic states manifested by tension anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)

The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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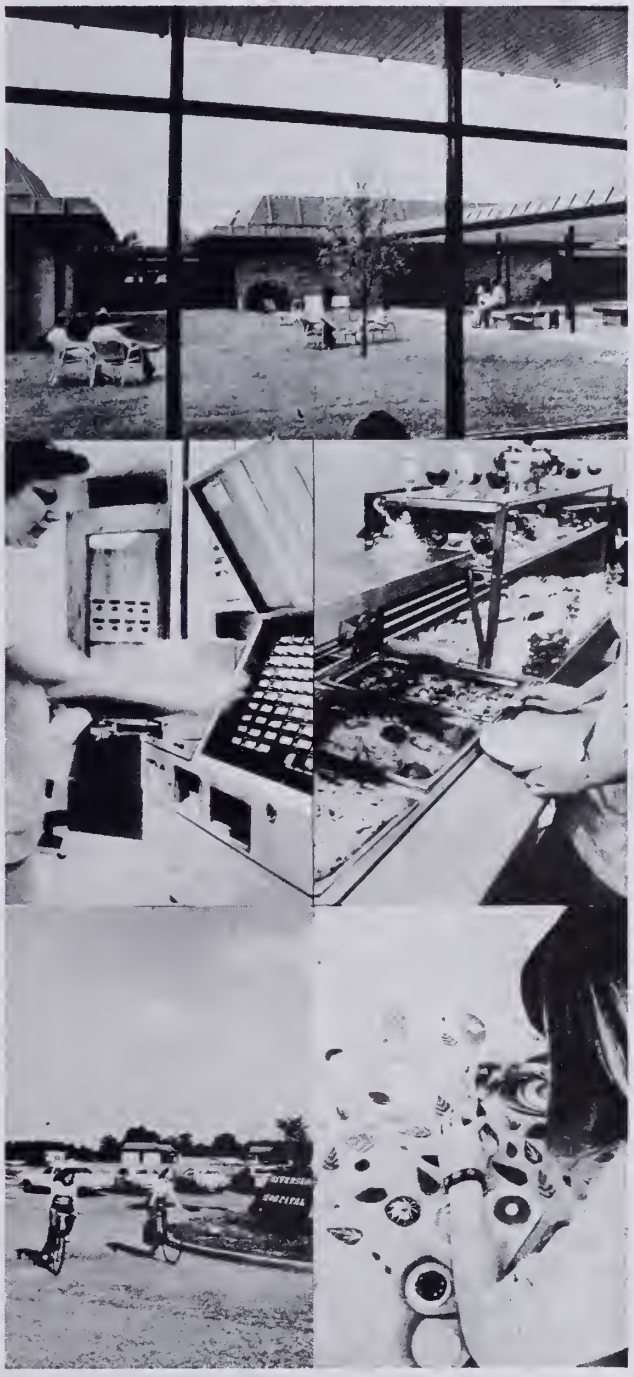
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CONTENTS

ORIGINAL PAPERS

Definitive Correction of Congenital Heart Disease in Infancy **179** FRED A. CRAWFORD, M.D., BOBBY J. HEATH, M.D., JAMES A. JORANSEN, M.D., and DAVID G. WATSON, M.D., Jackson, MS

Clinical and Laboratory Evaluation of Malabsorption **183** WILLIAM B. WILSON, M.D., Jackson, MS

SPECIAL ARTICLE

Radiologic Seminar CLXXXV: Subcapsular Hematoma of the Liver: A Case Report **186** GENE WARREN, M.D., Vicksburg, MS

EDITORIAL

Continuing Medical Education **191** MYRON W. LOCKEY, M.D., Jackson, MS

THIS MONTH

MSMA Auxiliary Page **189** Why AMA-ERF?

The President Speaking **190** A Professional and Public Consensus on Health

Medical Organization **197** Council on Scientific Assembly Plans 111th Annual Session

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GAO Reviews Programs For Health Manpower

Several federally supported programs directed at increasing the number of physicians in so called "shortage areas" were recently reviewed by the General Accounting Office, Congress's investigative arm.

Reporting on the National Health Service Corps, the GAO told Congress that the corps had undoubtedly increased the availability of physicians' services in communities designated by HEW as having a critical shortage of health manpower; however, "the corps has not adequately considered the demand for medical services when assessing the need for physicians in shortage areas . . . and this resulted in many physicians being underused in terms of patients served at sites operating one year or longer." It also raised "serious questions," according to GAO, concerning the extent of unmet demand for health care in some of the so-called "shortage areas."

The GAO further found with respect to the corps that from inception of the program through July 1976, only 42 physicians out of a total of about 800 who served in the corps, remained in the shortage areas as private practitioners, which is a major program objective.

As for the federal loan repayment program for medical students, the GAO found it relatively ineffective. "As of Oct. 31, 1977, the federal loan repayment program attracted only 762 physicians (about 1.7 per cent of those eligible) to shortage areas in return for loan repayment" the GAO reported. "Moreover, the majority of those who participated . . . probably would have established practices in those shortage areas anyway."

Two other programs, the preceptorship and family medicine training programs were too new at the time of the GAO's review to determine their impact on increasing the supply of physicians in shortage areas.

In a study conducted concurrently with its review of the several federal programs to alleviate physician shortages, GAO also tried to determine what factors affected the location decisions of a sample of physicians licensed in 1971 and found that "professional considerations, including clinical support, contact with other physicians, including clinical support and continuing education opportunities, played the largest role" in location decisions.

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Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows.

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Br

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e g , operating machinery, driving) Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated) Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines Observe usual precautions in presence of impaired renal or hepatic function Paradoxical reactions reported in psychiatric patients Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges Syncope reported in a few instances Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms increased and decreased libido—all infrequent generally controlled with dosage reduction changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy Adverse effects reported with Librax typical of anticholinergic agents, i e , dryness of mouth, blurring of vision, urinary hesitancy, constipation Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets

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Governors Do Not Support NHI

Newspaper reports indicate that Senator Edward M. Kennedy's impassionate plea for national health insurance at the recent National Governor's Conference apparently fell on deaf ears.

Kennedy who used his position as the keynote speaker for the conference to argue for immediate action on NHI failed to get a resolution of support from the nation's governors. The governors instead let stand a previously adopted resolution in opposition to a federally-dominated NHI program such as Kennedy's original Health Security Act and adopted a new policy position that "any federal law regarding health policy that may require alteration in state law be made effective no sooner than three years after enactment."

The mood of the governors toward new federal expenditures and taxes for health care and other programs was probably best indicated by a newspaper reporter's observation that "Mr. Jarvis and Proposition 13 permeated the meeting in spirit if not in person."

New CHAMPUS Forms Are Issued

Initial quantities of a new claim form and shorter Form 500 for physicians and other individual providers are being distributed by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) for immediate use, according to the CHAMPUS claims processing contractor for this area, *CHAMPUS Division, Mutual of Omaha, Dodge at 33 Street, Omaha, NE 68131.*

The new form, for reporting services and supplies furnished by professional (non-institutional) providers and suppliers to CHAMPUS beneficiaries and to beneficiaries of the Civilian Health and Medical Program of the Veterans Administration (CHAMPVA) replaces Form 1863-2. The beneficiary part of the new form requires some specific information that will enhance claims processing by CHAMPUS contractors.

The old claim form, 1863-2, will be phased out over the next several months. It will not be accepted after Jan. 31, 1979. Although the old claim form may be used during the interim period, use of the new form is encouraged because of the completion and processing advantages it offers.

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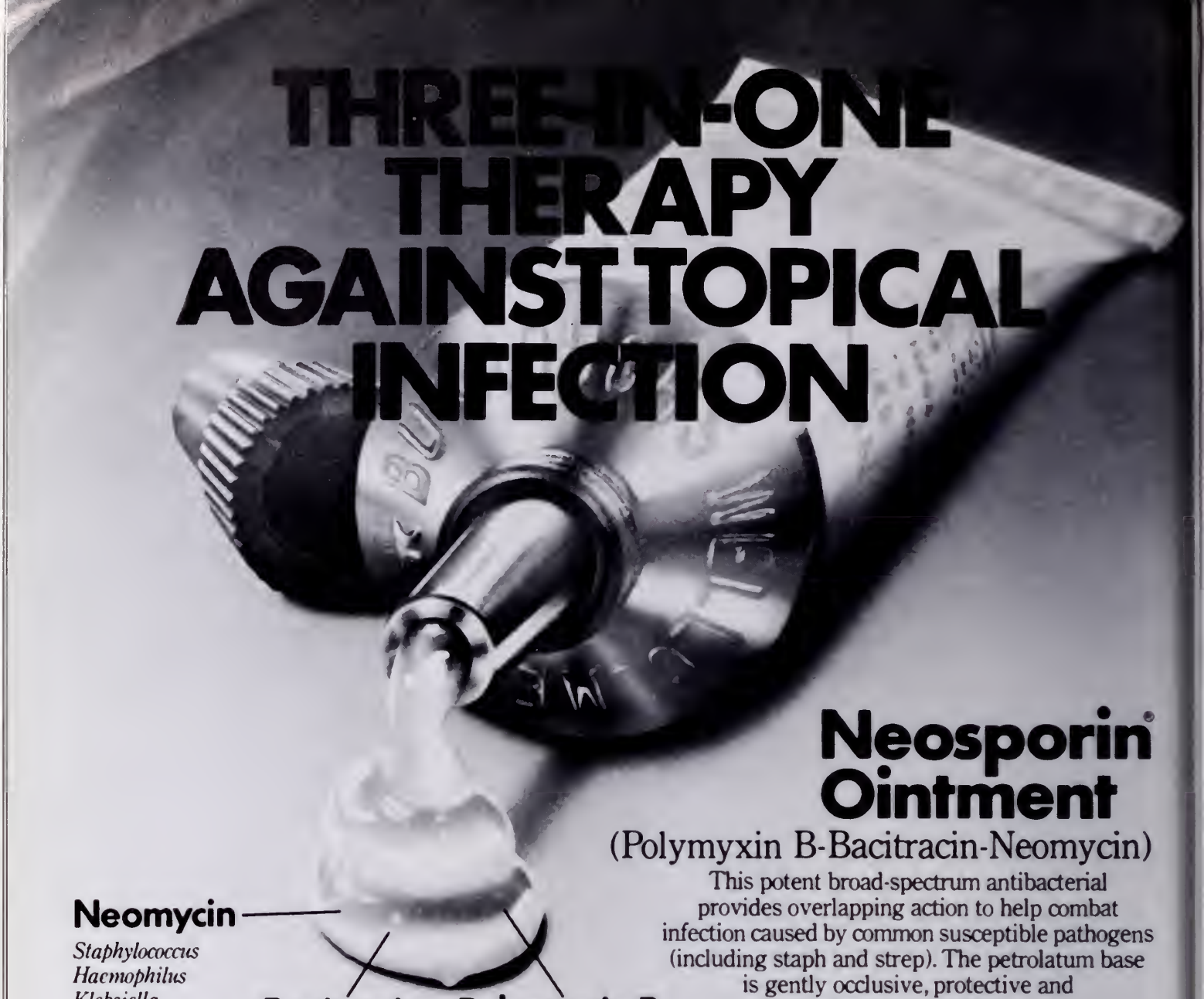
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Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base), special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching, it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

NEWSLETTER

October 1978

Dear Doctor:

Despite mounting inflation in the economy in general, the Voluntary Effort is succeeding in holding down the rate of increase in hospital expenditures, officials, of the voluntary program said at a news conference in Washington DC. The Voluntary Effort, initiated by the American Hospital Association, the Federation of American Hospitals, and AMA, seeks to reduce the rate of increase in hospital expenditures by 2% a year for the next two years.

> AMA told the government's Council on Wage and Price Stability that "for the good of the individual patient and for the good of the economy as a whole," the medical profession "will continue to seek to restrain cost increases not essential to good patient care."

Some 1496 students registered for fall classes at the University of Mississippi Medical Center, including 150 first-year medical students, coming to UMC after undergraduate work at 26 different colleges and universities. The new medical students bring enrollment in the medical school to nearly 600. Other students are in nursing, graduate medical education, dental, and allied health professional schools.

A check for $1,577, 372, from the AMA Auxiliary was presented to the AMA-Education and Research Foundation at the AMA's annual convention in June. Representing contributions from the "medical family," the check was the largest ever received by AMA-ERF. More than 5,000 medical students and physicians-in-training borrowed $7.3 million last year through AMA-ERF.

The Medical Association of Georgia (MAG) House of Delegates approved a proposal that the MAG should recommend to those currently involved in training and certifying physicians' assistants in Georgia that, until the need for more PAs can be documented, the training and certification of PAs in Georgia be terminated and that training programs be phased out as current training cycles end.

Pointing to passage of Rural Health Clinics Bill as a major achievement, American Nurses' Association admonished itself for not having made much headway in areas of entry into practice and reimbursement for nurses without supervision of physician in other than rural clinics. Priorities include recognition as independent practitioners under NHI, Medicare and Medicaid reimbursement and voluntary cost containment program.

Sincerely,

Nola Gibson

Nola Gibson
Magaging Editor

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Capsules and Powder for Oral Suspension



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- it isn't just for simple inflammation*
- it isn't just for simple cutaneous candidiasis*
- it isn't just for simple bacterial infection*



but how often is life so simple?

there's nothing quite like Mycolog® CREAM

Nystatin-Neomycin Sulfate-Gramicidin-Triamcinolone Acetonide Cream

Mycolog Cream (Nystatin — Neomycin Sulfate — Gramicidin — Triamcinolone Acetonide Cream) provides 100,000 units nystatin, neomycin sulfate equivalent to 2.5 mg. neomycin base, 0.25 mg. gramicidin, and 1 mg. triamcinolone acetonide (0.1%) per gram in an aqueous perfumed vanishing cream base.

* **INDICATIONS:** Based on a review of this preparation by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows. **Possibly effective:** In cutaneous candidiasis; superficial bacterial infections; the following conditions when complicated by candidal and/or bacterial infection: atopic, eczematoid, stasis, nummular, contact, or seborrheic dermatitis, neurodermatitis, and dermatitis venenata; infantile eczema; lichen simplex chronicus; and pruritus ani and pruritus vulvae.

Final classification of the less-than-effective indicotions requires further investigation.

CONTRAINDICATIONS: Viral diseases of the skin (such as vaccinia and varicella), fungal lesions of the skin except candidiasis, history of hypersensitivity to any product component. Not intended for ophthalmic use; should not be applied in the external auditory canal of patients with perforated eardrums; should not be used when circulation is markedly impaired.

WARNINGS: Because of the potential hazard of nephrotoxicity and ototoxicity, prolonged use or use of large amounts of this product should be avoided in the treatment of skin infections following extensive burns, trophic ulceration, and other conditions where absorption of neomycin is possible.

Usage in Pregnancy: Although topical steroids have not been reported to have an adverse effect on the fetus, the safety of topical steroids during pregnancy has not been absolutely established therefore, do not use extensively on pregnant patients, in large amounts, or for prolonged periods.

PRECAUTIONS: Watch constantly for overgrowth of nonsusceptible organisms (including fungi other than candida). Should superinfection due to nonsusceptible organisms occur, administer suitable concomitant antimicrobial therapy. If favorable response is not prompt, discontinue the preparation until adequate control by other anti-infectives is effected. If extensive areas are treated or if the occlusive technique is used, the possibility exists of increased systemic absorption of the corticosteroid, suitable precautions should be taken. If irritation develops, discontinue the product and institute appropriate therapy.

ADVERSE REACTIONS: Sensitivity reactions to topical use of gramicidin are rare. Hypersensitivity to nystatin is extremely uncommon. Hypersensitivity to neomycin has been reported and articles in the current medical literature indicate an increase in its prevalence.

The following local adverse reactions have been reported with topical corticosteroids either with or without occlusive dressings: burning sensations, itching, irritation, dryness, folliculitis, secondary infection, skin atrophy, striae, miliaria, hypertrichosis, acneform eruptions, maceration of the skin, and hypopigmentation. Contact sensitivity to a particular dressing material or adhesive may occur occasionally. Ototoxicity and nephrotoxicity have been reported.

For full prescribing information, consult package insert.

HOW SUPPLIED: Available in 15, 30, and 60 g tubes. It is also available in jars of 120 g (4 oz.) for hospital or institutional use only.

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SQUIBB® The Priceless Ingredient of every product is the honor and integrity of its maker.™

Medicare May Pay for "Free Care"

The federal government's efforts to enforce the "Hill-Burton free care obligation" may have backfired as a result of a decision by a U. S. District Court in Louisiana.

HEW which has recently gone through a process of identifying and requiring "free care" for indigent patients in hospitals funded under the Hill-Burton Program may now have to pay for such care under Medicare.

A U. S. District Court in Louisiana has ruled that Rapides General Hospital in Alexandria, LA, was justified in billing Medicare for its cost in providing free care to persons unable to pay as required by the Hill-Burton Act. The court agreed with Rapides General that the costs of fulfilling the Hill-Burton free care obligation were similar to other indirect patient care costs allowed under Medicare. The Justice Department has announced plans to appeal the decision of the District Court.

AMA Issues Directory of CME

The 24th annual listing of continuing education courses for physicians in the United States has been published as special issue of the Sept. 8 *Journal of the American Medical Association.*

The special issue lists 8,795 courses offered by 1,576 institutions in 48 states, the District of Columbia, Puerto Rico and the Virgin Islands from the period Sept. 1, 1978 to Aug. 31, 1979. This is a major increase over the number of courses offered last year, 7,330.

Internal medicine, with its subdivisions, is still the most popular field, with 1,650 courses. Next in size is psychiatry, with 1,426 courses listed. Other fields include general medicine, 796; radiology and radioisotopes, 535; pediatrics, 498; surgery, 466, and pathology, 432.

The list of courses is published by the AMA as a service to all physicians who are interested in maintaining their competence and skill through the medium of formal courses and other organized activities in continuing medical education. The AMA recognizes that there are many ways by which physicians may remain abreast of advances in medicine, and participation in formal courses is only one of them.

As of June 1, 1978, there was a continuing medical education requirement for either reregistration of the license to practice medicine, membership in the state medical society and/or as a condition for malpractice insurance in some 37 states.

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DISABILITY DETERMINATION SERVICES

Wishes to thank the physicians of Mississippi for your cooperation. Without your help our agency would be unable to properly process and adjudicate the thousands of applications made each year for disability benefits under the Social Security and Supplemental Security Income programs.

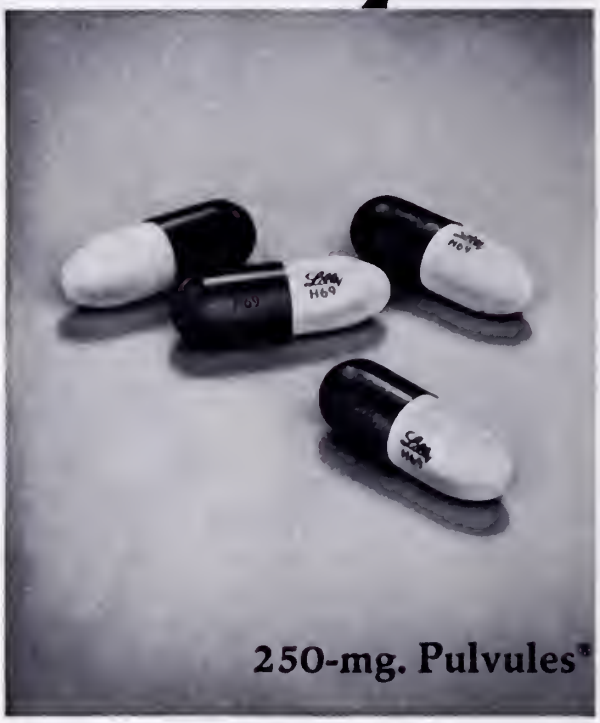
If you have any questions or need any information about our agency, please call or write:

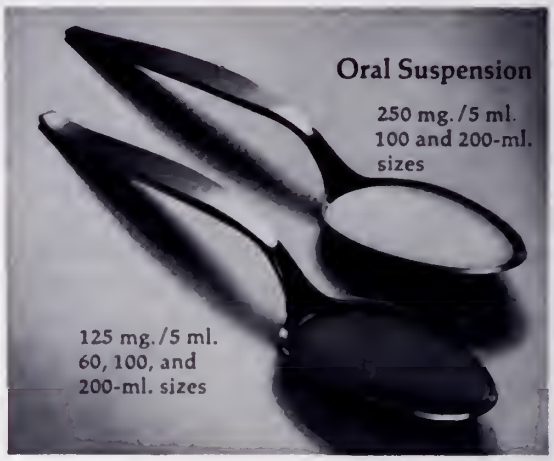
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John Barr, M.D.
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DATELINE

High Risk OBs Are Studied

New Orleans, LA - A new medical division which focuses on the problems of women with high-risk pregnancies has been established by the Ochsner Medical Institutions. The Division of Maternal-Fetal Medicine is the first of its kind to be formed at a privately-owned medical facility in Louisiana. The division, staffed by members of the Ochsner Clinic Department of Obstetrics and Gynecology and the Department of Pediatrics Section on Neonatology, offers a consultation and referral service for problem pregnancies.

Motorcyclists Wear Helmets

Chicago, IL - Motorcycle crash deaths are increasing sharply in the wake of at least 23 states overturning laws requiring riders to wear safety helmets, reports the AMA. In Wisconsin, for example, the State Department of Transportation reported that the death rate among motorcycle riders is 60% higher than for the same period last year(before the state law requiring helmets was changed). All motorcyclists should wear properly fitted, full-facial coverage helmets, advises AMA.

Non-Smokers Are Affected by Smoke

Long Beach, CA - A study at this California Veterans Administration Hospital shows that non-smokers who spend several hours in a closed room with individuals who smoke cigarettes show definite physiological effects from the smoke. Tests involved individuals with coronary heart disease and stable angina pectoris; exposure to other people's smoke caused anginal pain to develop sooner after exercise and increased patients' heart rates and blood pressures.

Bicycles Are Very Dangerous

Washington, DC - Despite a sharp increase in skateboard accidents, bicycles continue to be the most dangerous product, according to National Injury Information Clearinghouse. Top 10 hazards, clearinghouse said, are bicycles and related equipment; stairs, steps, and ramps; football activity and equipment; baseball activity and equipment; playground equipment; power mowers; skateboards, skates and scooters; swimming and swimming pools; nonglass tables; and beds, springs and bed frames.

Younger People Are Alcoholics

New York, NY - The largest survey ever made of recovered alcoholics shows a nearly 50% increase since 1974 in the percentage of people under 30 years of age in Alcoholics Anonymous. The study also revealed that 32% of the members coming to A.A. today are women. More young people and women indicated an addiction to drugs in addition to alcohol. More than 17,000 A.A. members worldwide participated in the largest and most comprehensive study of its kind ever undertaken.

Internists Protest Blue Shield Policy

Recent Blue Shield action in some states against patients using physicians who do not participate in the plan met bitter opposition at the annual session of the House of Delegates of the American Society of Internal Medicine.

The internists' action was sparked by decisions of Blue Shield in Michigan, Massachusetts, and New York to pay less to subscribers who go to non-participating physicians instead of a participation physician who agrees to accept as his full payment whatever the Blue Shield schedule stipulates.

The delegates also called on Medicare carriers to explain on their forms that Medicare's failure to pay the doctor's bill in full does not necessarily mean it is excessive.

Training in Ambulatory Care Is Stressed

More residency training should take place away from the hospital in an ambulatory care setting. . . . Practicing pediatricians should be utilized more as teachers in pediatric training programs. . . . Residency training should have an increased emphasis on training in biosocial pediatrics, adolescent medicine, and chronic illness care. . . . Pediatricians should have adequate input into the development of educational programs for pediatric nurse practitioners.

These were among a number of recommendations for improving pediatric education recently issued in a report which ended a two-year study by a Task Force on Pediatric Education.

The report includes general and specific recommendations for every phase of pediatric education from undergraduate and pediatric residency training to continuing education for practicing pediatricians, to training for pediatric nurse practitioners and pediatric education for family practice residents.

The group responsible for these recommendations, the Task Force on Pediatric Education, chaired by AAP Fellow C. Henry Kempe, M.D., is composed of representatives from 10 medical organizations concerned with the future of pediatric education. Formed in 1976, the Task Force was charged by its parent bodies with identifying emerging child health needs and determining educational strategies needed to prepare pediatricians of the future to meet these needs.

BRIEF SUMMARY OF
PRESCRIBING INFORMATION

ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017



When you're good people recognize you.

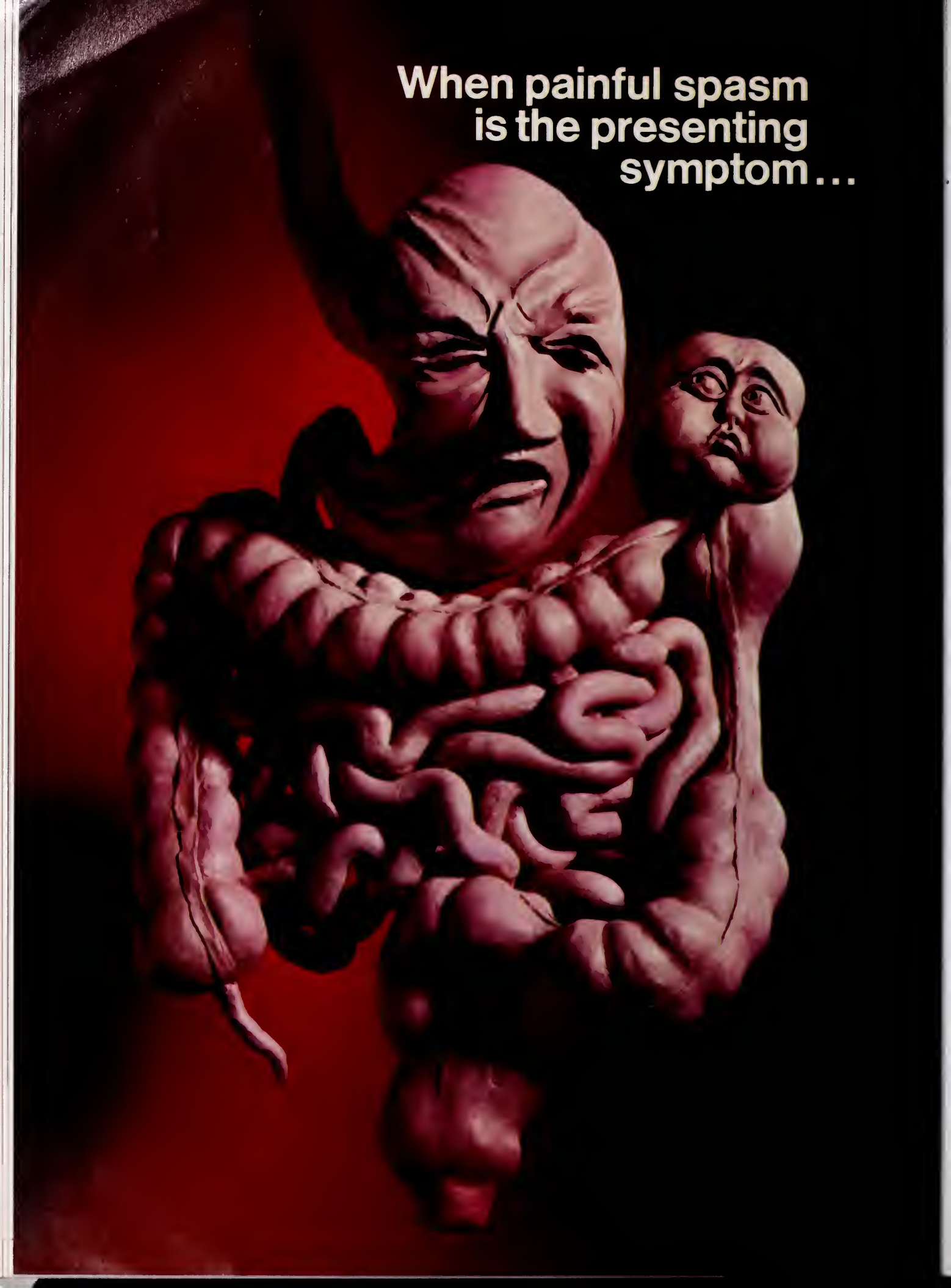
Highly effective
Single-dose convenience
Non-staining
Economical
Pleasant tasting

Antiminth®
(pyrantel pamoate)
equivalent to 50 mg pyrantel/ml
ORAL SUSPENSION

a drug of choice in pinworm infections

Please see brief summary of prescribing information on facing page.

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When painful spasm
is the presenting
symptom...

. in functional G.I. disorders*

Bentyl®

(dicyclomine hydrochloride USP)

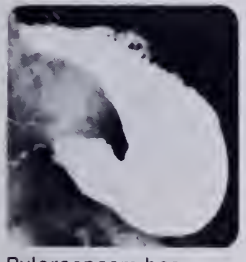
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

8-3497 (Y515A)

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION.

Brief Summary
INDICATIONS
For use as adjunctive therapy in the treatment of peptic ulcer.
IT SHOULD BE NOTED AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE OF ANTICHOLINERGICS/ANTISPASMODICS IN THE TREATMENT OF GASTRIC ULCER. IT HAS NOT BEEN SHOWN CONCLUSIVELY WHETHER ANTICHOLINERGIC/ANTISPASMODIC DRUGS AID IN THE HEALING OF A PEPTIC ULCER, DECREASE THE RATE OF RECURRENCES, OR PREVENT COMPLICATION.

Based on a review of this drug by the National Academy of Sciences–National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis, toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: autonomic neuropathy, hepatic or renal disease; ulcerative colitis–Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon; hyperthyroidism; coronary heart disease; congestive heart failure; cardiac arrhythmias; and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia, urinary hesitancy and retention, blurred vision and tachycardia, palpitations, mydriasis, cycloplegia, increased ocular tension, loss of taste, headache, nervousness, drowsiness, weakness, dizziness, insomnia, nausea, vomiting, impotence, suppression of lactation, constipation, bloated feeling, severe allergic reaction or drug idiosyncrasies including anaphylaxis, urticaria and other dermal manifestations, some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.
Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults*: 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children*: 1 capsule or teaspoonful syrup three or four times daily. *Infants*: ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults*: 1 tablet three or four times daily. Bentyl Injection: *Adults*: 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils; hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.
Product Information as of October, 1976

Merrell

MERRELL NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215 U.S.A.

Feds Report Millions In Overpayments

The Social Security Administration's Bureau of Supplemental Security Income (SSI) reports that it is mounting a new effort to recover $125 million in overpayments to 61,000 persons in the welfare program for the poor, blind and disabled during the period 1974-76.

Blaming "computer problems," SSI states that it is still making overpayments at the rate of nearly $300 million annually but the error rate has dropped steadily to 4.6 per cent and is far below the 8.7 per cent rate in the government's other major welfare program, Aid to Families with Dependent Children. SSI and Aid to Families with Dependent Children recipients are also eligible for Medicaid.

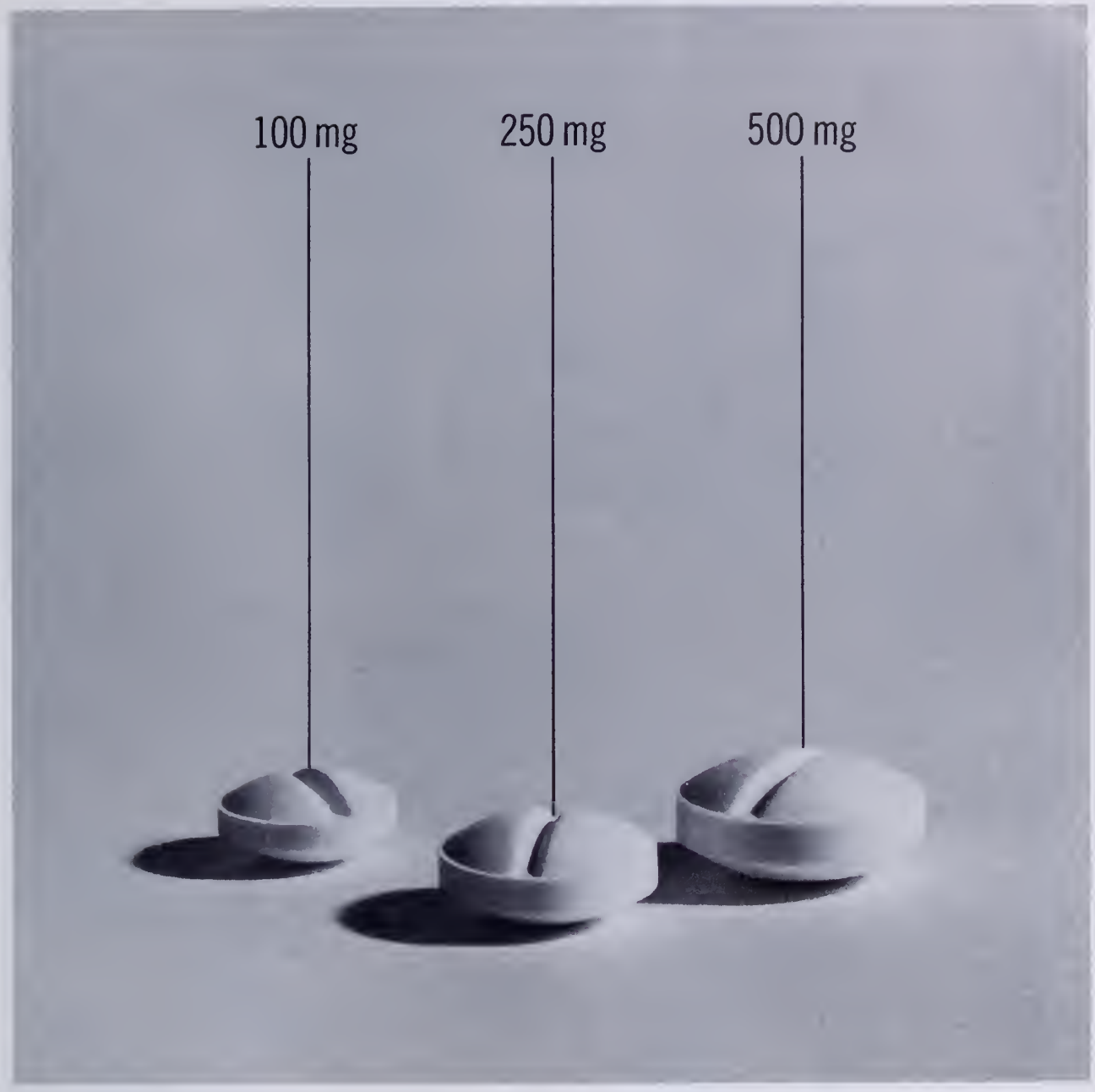
New Rules Hit Teaching Hospitals

Proposed new Medicare and Medicaid reimbursement rules may have a very adverse effect on teaching hospitals according to the Association of American Medical Colleges.

The new rules require, for the first time, that at least 85 per cent of the inpatients in a teaching hospital receive their care from a personal or attending physician other than house staff if any patient in the hospital is to be considered a "private patient" with respect to Medicare and Medicaid reimbursement. If a hospital cannot meet this standard, no professional fees could be billed for any patient in that hospital. Outpatients at teaching hospitals would not have to meet the same standards.

The proposed new rules are intended to prevent a longstanding practice, documented in several federal reports, of teaching physicians billing professional fees while interns and residents actually provide the patient care.

The draft rules include new methods for calculating "reasonable charges" for teaching physician services which take into account such factors as the physician's salary and benefits from a medical school and the precise services the physician provides to patients. In some cases a new "schedule of allowances" for physician charges would be used to calculate Medicare payments which could not exceed 40 per cent of the prevailing charge for similar services in neighboring hospitals.



Tolinase®
tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

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Brief Summary of Prescribing Information

Actions: Pyrvinium pamoate appears to exert its anthelmintic effect by preventing the parasite from using exogenous carbohydrates. The parasite's endogenous reserves are depleted, and it dies. Povan is not appreciably absorbed from the gastrointestinal tract.

Indication: Povan is indicated for the treatment of enterobiasis.

Warnings: No animal or human reproduction studies have been performed. Therefore, the use of this drug during pregnancy requires that the potential benefits be weighed against its possible hazards to the mother and fetus.

Precautions: To forestall undue concern and help avoid accidental staining, patients and parents should be advised of the staining properties of Povan. Care should be exercised not to spill the suspension because it will stain most materials. Tablets should be swallowed whole to avoid staining of teeth. Parents and patients should be informed that pyrvinium pamoate will color the stool a bright red. This is not harmful to the patient. If emesis occurs, the vomitus will probably be colored red and will stain most materials.

Adverse Reactions: Nausea, vomiting, cramping, diarrhea, and hypersensitivity reactions (photosensitization and other allergic reactions) have been reported. The gastrointestinal reactions occur more often in older children and adults who have received large doses. Emesis is more frequently seen with Povan Suspension than with Povan Filmseals.

How Supplied: Each Povan Filmseal® contains pyrvinium pamoate equivalent to 50 mg pyrvinium, supplied in bottles of 50 (NDC 0710-0747-50; NSN 6505-00-134-1966). Povan Suspension, a pleasant-tasting, strawberry-flavored preparation containing pyrvinium pamoate equivalent to 10 mg pyrvinium per milliliter, is supplied in 2-oz bottles (NDC 0071-1254-31; NSN 6505-00-890-1093).

RC/RD PD-JA 1699-2 P (8-76)

Parke, Davis & Company
Detroit, Michigan 48232

When it's pinworms, treat the family



Povan® (pyrvinium pamoate)

- over 17 years of proved clinical effectiveness and safety
- no measurable absorption from the GI tract—minimal systemic side effects
- one dose—one time—that's all that's usually required
- two dosage forms: Tablets and Suspension—suitable for the entire family

Povan—there's a form for every member of the family.

PARKE-DAVIS

JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
October 1978, Vol. XIX, No. 10

ORIGINAL PAPERS

Definitive Correction of Congenital Heart Disease in Infancy

FRED A. CRAWFORD, JR., M.D., BOBBY J. HEATH, M.D.,
JAMES A. JORANSEN, M.D., and DAVID G. WATSON, M.D.
Jackson, Mississippi

THE DEFINITIVE TREATMENT of congenital heart disease began in 1938 when Gross first successfully ligated a patent ductus arteriosus (PDA). The modern era of the correction of congenital intracardiac defects began in 1953 with the development of the pump oxygenator by Gibbon and its successful application in the closure of an atrial septal defect. Since that time, further refinements in technique have made possible correction of most congenital heart defects. Some procedures, such as correction of atrial septal defects, have become well standardized and have not changed recently. The management of some other congenital heart defects such as ventricular septal defect (VSD), Tetralogy of Fallot, atrio-ventricular canal, and others has changed significantly in the past few years, primarily in that definitive surgery is being carried out at a much earlier age.[1-3] It is the purpose of this communication to describe changes in technique or philosophy which have occurred recently.

Patent Ductus Arteriosus

G.H., a 700 gm (1.5 pound) baby of a 27 weeks gestation, developed respiratory distress almost immediately after birth and was placed on a ventilator. A continuous murmur and bounding pulses were subsequently noted and chest x-ray demonstrated a left to right shunt. A diagnosis of patent ductus arteriosus (PDA) was made and treatment begun with digitalis and diuretics. Despite initial improvement, she could not be weaned from the respirator and congestive heart failure persisted. After 15 days of respiratory support, a large PDA was ligated. Improvement was almost immediate and she was removed from the ventilator some 12 hours later. She was subsequently discharged, weighing 2,080 gms, and has continued to do well.

Improvements in diagnosis, anesthesia, respiratory support, cardiopulmonary bypass and surgical techniques have enabled a change in philosophy regarding several congenital heart defects. The most important change has been from the previous policy of palliation in infancy followed by total correction at a later age to one of total correction in infancy. Illustrative case histories as well as discussion of these changes as regards patent ductus arteriosus, ventricular septal defect, atrioventricular canal, transposition of the great arteries, and total anomalous pulmonary venous return are discussed in this report.

While the technique of PDA ligation has not changed, it is now being applied to a group of patients such as this one who were not previously considered surgical candidates. The vast improvement in techniques for management of the premature, low birth weight infant has resulted in survival of a significant number of such children who previously would have died.[4] These infants frequently have immature lungs and are hypoxic. Since oxygen is a stimulus for ductal closure, in these hypoxic infants the duct may remain open. This can result in congestive heart failure or increased respiratory distress secondary to the left to right shunt. The size of the ductus can reliably be estimated non-invasively by echocardiography and only rarely is cardiac catheterization necessary. Initial attempts at surgical

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closure of the ductus in these children were unsuccessful due to the problems of operating on such small infants. In the past 24 months, 30 such infants weighing less than 2500 gms (including 16 less than 1,000 gms) have undergone ductal closure at the University of Mississippi Medical Center without an operative death and with 86 per cent living to be discharged. Recently some investigators have shown that Indomethacin and other prostaglandin inhibitors can stimulate ductal closure, but there have also been complications of this nonsurgical approach. Because of these possible complications and the low mortality in our experience, we have continued to be aggressive in the surgical interruption of PDA in neonates. Recent improvements in anesthetic management, fluid regulation, temperature control, and surgical technique have resulted in a considerably improved outlook for these children. As a result, the prognosis for such children has been considerably improved.

Ventricular Septal Defect

C.W., a 3 kg female, was referred to the University Medical Center at age 10 weeks for evaluation of severe congestive heart failure. Physical examination revealed a tachypneic female with a grade V/VI holosystolic murmur and hepatomegaly. Chest x-ray showed cardiomegaly and increased pulmonary vascularity. Cardiac catheterization on Oct. 31, 1977, showed pulmonary hypertension, a PDA and a pulmonary:systemic flow rates of 6:1 through a large ventriculoseptal defect (VSD). Because of failure to respond to maximal medical therapy, on Nov. 2, 1977, the PDA was ligated and the VSD closed with a patch. In order to facilitate surgery, the patient's temperature was decreased to 24° C, pump flow decreased to one-fourth normal, and the heart arrested for 50 minutes with a 4° C potassium cardioplegia solution. The postoperative course was uneventful and she is currently well and on no medications.

The repair of VSD in older children has become well standardized. However when severe congestive failure occurred in infancy, the standard treatment until recently has been to constrict the pulmonary artery with a band to decrease pulmonary blood flow and to prevent the development of pulmonary hypertension. While this approach was successful in many patients, it does have several drawbacks including a significant morbidity and mortality and failure to always prevent pulmonary vascular changes. A second operation is required some years later to remove the band and close the VSD and this operation also has its own morbidity and mortality. Pulmonary artery banding was initially chosen because primary repair in infancy was associated with a higher operative mortality than the two stage approach. Recently successful primary repair has been accomplished in infants with a much lower operative mortality than previously reported.[2, 5] This initially was due to the use of a technique called "profound hypothermia with total circulatory arrest" in which the patient's temperature was lowered to 18-20° C and cardiopulmonary bypass stopped. Perfusion cannulae were removed and this provided optimal circumstances for intracardiac surgery, i.e. a flaccid, bloodless, heart. However, the period of arrest was limited to about 1 hour. As more infants were operated upon using this technique, it became apparent that with very few exceptions, almost equivalent working conditions could be obtained without turning off the pump by simply decreasing pump flow. While some have continued to use the "total circulatory arrest" technique, at the University of Mississippi Medical Center we have chosen to use the modified technique described above believing it to be safer. Other factors which have improved the safety of surgery in such tiny infants include closing the defect through the right atrium and thus avoiding the bad effects which occur with incisions into the right ventricle. The use of profound cardiac hypothermia and potassium cardioplegia have further improved the working conditions and the safety of the procedure. With these improvements, the primary definitive correction of VSD in infancy can be accomplished with a risk of less than 5 per cent. In the past 12 months, 14 infants less than 24 months old have undergone primary closure of a VSD at the University Medical Center. All survived the procedure and are presently doing well. We now repair all such defects primarily in infancy. Pulmonary artery banding is reserved for multiple muscular ventricular septal defects or for defects such as common ventricle for which at the present time there is no definitive correction.

Atrioventricular Canal

T.R., a 15 month, 7 kg male, was referred to the University Medical Center at age 3 months for evaluation of congestive heart failure. Chest x-ray showed cardiomegaly and increased pulmonary vasculature. EKG showed left axis deviation and the clinical diagnosis was atrio-ventricular canal. He was treated with digitalis and diuretics with some improvement. Cardiac catheterization in July 1977 demonstrated complete atrio-ventricular canal consisting of atrial septal defect, ventricular septal de-

fect, common AV valves, and mitral insufficiency. Because of increased congestive heart failure, on Sept. 28, 1977, the defect was repaired by closing the atrial and ventricular septal defects with a patch. The AV valves were divided into mitral and tricuspid components, reconstructed, and resuspended from the patch closing the septal defects.

In order to facilitate surgery, the patient was cooled to 24° C, pump flow decreased, and the heart arrested for 63 minutes with a 4° C potassium cardioplegia solution. The postoperative course was uneventful and he remains well, in sinus rhythm, without evidence of residual shunt or mitral insufficiency.

The atrio-ventricular canal is a special kind of VSD with coexisting defects in the mitral and tricuspid valves and the atrial septum. Because of the extremely high operative mortality, even in older children, the initial treatment of such infants in the past has also been pulmonary artery banding. Like the standard VSD, this necessitated a second operation at a later date. Several years ago the operative mortality in such children began to decrease because of improvements in the techniques of repair due to better understanding of the anatomy of the defect. Because of this, the improved techniques for definitive cardiac surgery in infants described earlier, and the problems with pulmonary bands already discussed, we now prefer to avoid pulmonary artery banding in these infants and proceed with definitive correction in infancy. This can be done as in this child with a risk of about 5 per cent.

Tetralogy of Fallot

T.M. was noted to be cyanotic at birth. Physical examination, electrocardiogram and chest x-ray were consistent with Tetralogy of Fallot. Because of increasing cyanosis, cardiac catheterization at age 2 revealed a Tetralogy of Fallot with a large VSD, marked infundibular stenosis, and an overriding aorta. Two months later on June 28, 1977, total correction was carried out by closing the VSD with a patch and resecting the infundibular stenosis. At the time of surgery, the patient's temperature was lowered to 26° C and the heart arrested for 39 minutes with a 4° C potassium cardioplegia solution. Postoperative studies revealed a normal right ventricular pressure and no residual shunt. The postoperative course was uneventful and she remains well, asymptomatic, and without evidence of residual defect one year later.

Tetralogy of Fallot is a defect in which there is inadequate blood flow to the lungs. Blalock devised the subclavian artery-pulmonary artery shunt which increased the pulmonary blood flow and thus improved the outlook for these infants. For many years this or other systemic-pulmonary shunts such as the Waterston shunt remained the standard form of treatment for patients with Tetralogy of Fallot and severe cyanosis. When the child got older and bigger, the shunt was "taken down" and definitive correction accomplished by closing the VSD and relieving the obstruction to pulmonary blood flow. Again this required 2 or more operations, each with its own significant morbidity and mortality. Not infrequently a child died between the initial shunt and the time total correction could be performed. Again about 1970, using the techniques of profound hypothermia previously described, several groups began to report total correction of Tetralogy of Fallot in infancy with the risk (about 5-8 per cent) less than the combined risk of shunting and later total correction. There are several distinct contraindications to primary correction in infancy such as an extremely small pulmonary artery and anomalous coronary arteries. While some still prefer to do an initial shunt followed by total correction at a later date, most centers doing pediatric cardiac surgery have chosen primary correction in infancy. At the University of Mississippi Medical Center, we prefer to go ahead with primary total correction as long as the anatomy is favorable as it was in this patient. In those with unfavorable anatomy, an initial shunting procedure is selected.

Transposition of Great Arteries

T.M., an 8 kg female, was referred to the University of Mississippi Medical Center at age 2 weeks for evaluation of cyanosis. At catheterization, transposition of the great arteries with an intact ventricular septum was demonstrated and a balloon atrial septostomy was performed. Because of continued cyanosis, she subsequently underwent an open atrial septectomy using inflow occlusion with improvement. At age 18 months she was felt to be a candidate for surgical correction and on Jan. 31, 1978, an intra-atrial baffle as described by Mustard was constructed to direct caval blood flow through the mitral valve into the left ventricle and out the pulmonary artery and pulmonary venous return through the tricuspid valve, the right ventricle and out the aorta. The temperature was lowered to 24° C, pump flow decreased to one-fourth normal, and the heart arrested for 50 minutes using a 4° C potassium cardioplegia solution. The postoperative course was smooth and she remains well and in sinus rhythm.

The standard treatment for transposition of the great arteries is balloon atrial septostomy at initial

catheterization to improve atrial mixing. This improvement usually lasts from 6 to 18 months and at that point a definitive procedure such as the intra-atrial baffle procedure of Mustard is carried out. In this child the balloon atrial septostomy did not significantly improve mixing and as a result a second procedure, an atrial septectomy, was carried out. While the result in this patient was good, both initially and at the time of definitive correction, we would now omit the second procedure of open atrial septectomy and proceed directly with the Mustard procedure at any age when it became apparent that the balloon atrial septostomy was inadequate. Again this is because of the newer techniques already described which allow for primary intracardiac repair at an earlier age.[6]

Total Anomalous Pulmonary Venous Return

J.K., a 3-year-old, was referred to the University Medical Center for evaluation of failure to thrive and shortness of breath. Physical examination showed a poorly developed male who was in less than the third percentile for height and weight. A short systolic ejection murmur was noted. Chest x-ray showed cardiomegaly, pulmonary venous congestion, and a wide superior mediastinum. Catheterization showed Type I (supracardiac) total anomalous pulmonary venous return to the superior vena cava by way of a vertical vein into the left innominate vein. At surgery temperature was decreased to 22° C and pump flow decreased to one-fourth normal. The common pulmonary vein was anastomosed to the posterior left atrium and the vertical vein ligated. His postoperative course was completely uneventful and he is now asymptomatic with progressively improving height and weight.

Total anomalous pulmonary venous drainage is a condition in which the pulmonary veins drain into the superior vena cava, inferior vena cava, or right atrium instead of the left atrium. In the past the operative correction of this disorder has been extremely difficult, particularly in the infant and it has had a significant mortality. The techniques previously described including total circulatory arrest have resulted in significant improvement in the results of surgical correction.[7] While standard perfusion techniques were used in this patient because of his size, the technique of total circulatory arrest is particularly useful in this defect because of the increased exposure which it provides. Correction of these disorders can now be accomplished with a risk of 10-20 per cent compared to 35-50 per cent only a few years ago.

Discussion

It should be stressed that early surgery is totally dependent on precise, accurate diagnosis best obtained by biplane angiocardiography in multiple views. These improvements in diagnosis, anesthesia, respiratory support, cardiopulmonary bypass, and surgical techniques have resulted in improved results in all types of cardiac surgery. These developments have been of such great magnitude that they have enabled a complete change in philosophy regarding several congenital defects. While some defects such as tricuspid atresia and common ventricle still have to be approached with the initial goal of palliation, hopefully to be followed later by corrective surgery, others including those discussed above may now be approached with the goal of primary total correction in infancy. In addition to improved morbidity and mortality, other benefits associated with early definitive repair include improved psychological adjustment of both parent and child and improvement in growth patterns following repair. Because of this, the prognosis of infants born with congenital heart disease is steadily improving. ★★★

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"Too bad that all the people who know how to run the country are busy driving taxicabs and cutting hair." — *George Burns*

Clinical and Laboratory Evaluation of Malabsorption

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ALMOST ALL TYPES of malabsorption involve failure to absorb fat, and therefore the syndrome can be defined in terms of steatorrhea. If excessive fat loss is absent, then clinically significant malabsorption is very unlikely,[1,2] with a few exceptions mentioned below. Therefore, the diagnosis of malabsorption depends basically upon demonstration of excessive fecal fat excretion.

Physiology of Fat Absorption

Normal fat intake is 50 to 100 gms per day, consisting mainly of triglycerides of long chain fatty acids. The pancreas secretes lipase, which hydrolyzes these fats to monoglycerides and fatty acids. The substances are aggregated into micelles by the detergent action of bile salts. The micelles are absorbed by the small bowel epithelium, re-esterified into triglycerides, coated with lipoproteins, absorbed into the lymphatics, and delivered into the venous circulation. The bile salts, meanwhile, are 85 per cent re-absorbed in the distal ileum and returned to the liver.

Pathologic Physiology

Disorders of any of the above steps may lead to steatorrhea.[1] *Lipase deficiency* may result from chronic pancreatitis, but only in very advanced cases; relative lipase deficiency may occur when excess fat is delivered into the small bowel following a Billroth II operation; or lipase may be inactivated by excess gastric acid in the duodenum, as in Zollinger-Ellison syndrome. *Impaired micelle formation* may occur as a result of inadequate bile salt secretion following surgical resection of the ileum and deficient bile salt resorption; or from bile salt inactivation due to excess gastric acid in the duodenum; or from deconjugation of bile salts by bacterial overgrowth in the normally sterile small bowel. Bacterial overgrowth may follow anything causing stasis or sluggish movement of small bowel contents, such as strictures, blind loops, diverticula, or Billroth II surgery with sluggish afferent loop.

Almost all types of malabsorption involve failure to absorb fat, thus the syndrome can be defined in terms of steatorrhea. The author discusses physiology of fat absorption, pathologic physiology, the clinical approach, mucosal biopsy, diseases which cannot be diagnosed by jejunal biopsy, and additional tests used in evaluating malabsorption.

Deficient transport of micelles into the gut epithelium may result simply from inadequate absorptive surface, such as in major resection of small bowel, or fistulas bypassing part of the small bowel; or it may occur with primary intestinal mucosal disease, such as gluten enteropathy (celiac disease or non-tropical sprue), tropical sprue, blocked lymphatic drainage, and degenerative or inflammatory diseases of the small bowel. *Combinations of the above mechanisms* occur frequently, such as inadequate absorption surface and inadequate bile salt re-absorption in the short gut syndrome; lymphomas, causing both lymphatic blockage and atrophy of the mucosal villi; and Billroth II surgery causing decreased absorptive surface, bacterial overgrowth, and delayed pancreatic secretory response. Certain specific absorptive defects, such as pernicious anemia, intestinal lactase deficiency, and Hartnup's disease are unrelated to steatorrhea.

Clinical Presentation[1]

The patient with malabsorption may present with frank steatorrhea and weight loss, or with only chronic diarrhea of varying severity; or he may present symptoms related to deficiencies of fat soluble vitamins, especially D (skeletal pain or even tetany); occasionally Vitamin K deficiency (bleeding diathesis); or, rarely, A deficiency. Muscular weakness

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due to potassium deficiency may occur. Anemia is a common initial finding in malabsorption, due to deficient absorption of iron and folate, and unexplained anemia may be a fortuitous clue to the presence of malabsorption, as may low cholesterol, low albumin, low calcium, or flat glucose tolerance curve. The finding of low blood carotene indicates long term malabsorption.

Clinical Approach

The clinical evaluation of the patient with malabsorption begins with a history and physical examination. The history, especially concerning abdominal surgery, often leads directly to a strong presumptive diagnosis. Next, the presence or absence of steatorrhea must be determined. A screening test consists of emulsifying a small bit of stool, such as may be obtained on rectal examination, with a drop of acetic acid on a glass slide, heating it gently, adding a fat stain, cover slipping, and examining for fat droplets under the microscope.[3] Provided the patient has had a normal fat intake, the absence or near absence of stainable fat (which may be checked with a control sample of normal stool) excludes malabsorption with reasonable certainty and no further investigation is necessary.[1] However, one should be sure the patient has been on a normal fat intake, as patients with steatorrhea tend to avoid fatty foods. Excessive urinary excretion of an oral oxalate load correlates with steatorrhea, and can be used as a test for malabsorption.[7]

If any doubt remains concerning the screening test, a quantitative fecal fat study must be carried out. This consists of putting the patient on a five-day high fat diet (80 to 100 gms per day), during the last three days of which the patient makes a 72-hour stool collection. The fat content of the stool is measured quantitatively by the rather involved Van de Kamer method.[4] A normal value should be less than 5 to 7 gms of fat excreted per day. If a three-day collection is not possible, a single stool may be quantitatively measured, in which case, fat should not exceed 15 to 25 per cent of the dry weight of the stool.[2]

Having established the presence of steatorrhea, the next test to perform is a small bowel x-ray,[1] which may yield considerable information: namely, the mucosal pattern of the small bowel, which may show characteristic (but non-specific) changes of malabsorption; evidence of any factors leading to stasis, as previously described; evidence of ulcerative or inflammatory disease, or presence of a surgically shortened small bowel. If stasis and short bowel are absent, the next most productive test[1] is small bowel intubation, to obtain a mucosal biopsy near the ligament of Treitz, and, in addition, aspirated contents for pH determination, cultures (both aerobic and anaerobic); and possibly parasite examination (giardiasis, especially in children, and occasionally strongyloidiasis). Acid pH indicates excess gastric acid in the small bowel. Cultures must be done quantitatively, as a significant bacterial excess in the small bowel is indicated only by 10^7 or more organisms per ml.[2] The most commonly found bacteria are bacterioides, anaerobic lactobaccilli, coliforms, and enterococci. The mucosal sample obtained by biopsy must be laid flat, as on a piece of paper, fixed in this position, and sectioned in an exactly perpendicular plane, for proper microscopic examination.[2]

Mucosal Biopsy

Diseases which can be diagnosed or strongly suspected on mucosal biopsy[1-3] include celiac disease, tropical sprue, refractory sprue, infectious gastroenteritis, and stasis syndrome. Others include Whipple's disease, with characteristic PAS positive macrophages (and bacillus-like structures on electron microscopy); primary lymphoma, with malignant cells and villous atrophy; lymphangiectasia; mast cell disease; collagenous sprue, with collagen deposition in the mucosa; giardiasis or strongyloidiasis, if the parasites can be demonstrated; immuno-deficiency syndromes (absent plasma cells in the small bowel mucosa); eosinophilic gastroenteritis (probably milk allergy); diffuse ileojejunitis (not to be confused with Crohn's disease); Zollinger-Ellison syndrome, with characteristic patchy ulceration; scleroderma; radiation enteritis; coccidioidomycosis; histoplasmosis; tuberculosis; the celiac-like changes seen in dermatitis herpetiformis; abetalipoproteinemia, with characteristic lipid vacuoles; and kwashiorkor.

Other Diseases

Diseases which cannot be diagnosed by jejunal biopsy include malabsorption associated with pancreatitis, alcoholism, cirrhosis, hepatitis, postgastrectomy syndromes, cholera, hookworm, iron deficiency anemia, chronic ulcerative colitis, and dermatoses other than dermatitis herpetiformis.[2]

Malabsorption may also be associated with specific drugs, such as colchicine and neomycin (mucosal enzyme poisons); para-amino salicylic acid; and cholestyramine, which binds bile salts. Ischemic bowel disease is diagnosed by x-ray and angiography. Short gut syndrome may have true

malabsorption, or may have simple diarrhea without malabsorption, due to leakage of bile salts into the colon. Diabetes mellitus has received attention as a possible cause of malabsorption, but actually is an unusual cause even in severe diabetics. Such patients should be evaluated as non-diabetics.[1]

Additional Tests

Several other tests may be used in evaluating malabsorption. In performing the *secretin test* for pancreatic function,[5] a tube is placed in the duodenum, and purified secretin given IM or IV. Duodenal aspiration is made for 30 minutes, monitoring the pH frequently to exclude gastric juice contamination, which would invalidate the test. Pancreatic function is evaluated in terms of bicarbonate secretion, the normal response being 15 millimoles of bicarbonate, within 30 minutes, at a concentration around 100 millimoles per liter. This is a general test of pancreatic function, without much value in differential diagnosis, and does not become positive until the pancreas is 90 per cent destroyed. One may also monitor serum amylase during the test, which, if it rises, would suggest obstruction of the pancreatic duct. The test is not often indicated, and is contraindicated in pancreatitis.

Direct measurement of fat absorption at one time experienced popularity. *Labeled triolein,* which requires lipase for absorption, is given orally, and the serum level, as well as three-day stool excretion, is measured. The procedure can then be repeated using *labeled oleic acid,* which does not require lipase, as a test of mucosal integrity. These tests are considered no longer acceptable because of insensitivity, and the high incidence of false positives and false negatives, resulting from such complications as variable gastric emptying and contamination of triolein preparations with oleic acid.[2]

A simple and accurate test for measuring deconjugation of bile salts by bacteria has been devised, in which *^{14}C-labeled bile salt* is given orally, and the excretion of ^{14}C-labeled CO_2 in the breath measured by absorbing it in a weak acid and counting the radioactivity.[6] Normally little ^{14}C would be absorbed (less than 2.5 per cent of the administered dose). In the presence of bacterial overgrowth, in which the labeled bile salts are deconjugated, 16 to 30 per cent is absorbed and excreted. In the presence of ileal resection, 27 to 36 per cent is excreted, since the bile salts reach the colon, where they are even more massively destroyed by the colon bacteria, with subsequent absorption. This test not only permits the diagnosis of significant bacterial overgrowth in the small bowel, but permits evaluation of antibiotic therapy for this condition, which, when successful, will cause the results to return to normal. However, quantitative breath samples must be collected each hour for up to 24 hours, somewhat restricting the test's usefulness.

A test which is useful and easy to do is the *d-xylose test,* which measures the functional integrity of the jejunal mucosa, independent of the pancreas, provided massive bacterial overgrowth, anemia, renal disease, and liver disease are absent.[1-3] This test is most useful in diagnosing sprue syndromes. A 25-gm test dose is given orally, and the 5-hour urinary excretion measured, which normally exceeds 4 gms. The test may also be done using a 5-gm dose, which is better tolerated by the patient, but less sensitive.

In the same way jejunal functional integrity can be measured by the d-xylose test, ileal functional integrity can be measured using the *Schilling test,* since Vitamin B_{12}, after being acted on by intrinsic factor in the stomach, is absorbed in the ileum. Failure of normal absorption of B_{12} can be due to pernicious anemia, bacterial overgrowth, or ileal insufficiency. The first can be excluded by repeating the test with intrinsic factor, and the second by pretreatment with antibiotics. Absence of normal absorption after these maneuvers indicates ileal insufficiency.[1-3] ★★★

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"The closest to perfection a person ever comes is when he fills out a job application form."

— Stanley J. Randall

Radiologic Seminar CLXXXV: Subcapsular Hematoma of the Liver: A Case Report

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IN THE SPECTRUM of traumatic liver injuries, subcapsular hematoma is infrequent. In two large series of patients with liver rupture the incidence was less than one per cent. Early diagnosis of any liver injury is desirable because of a high mortality rate and a significant complication rate with delayed diagnosis. Unfortunately, patients with significant liver injury are often in apparently good condition on admission. A high index of suspicion is therefore helpful.

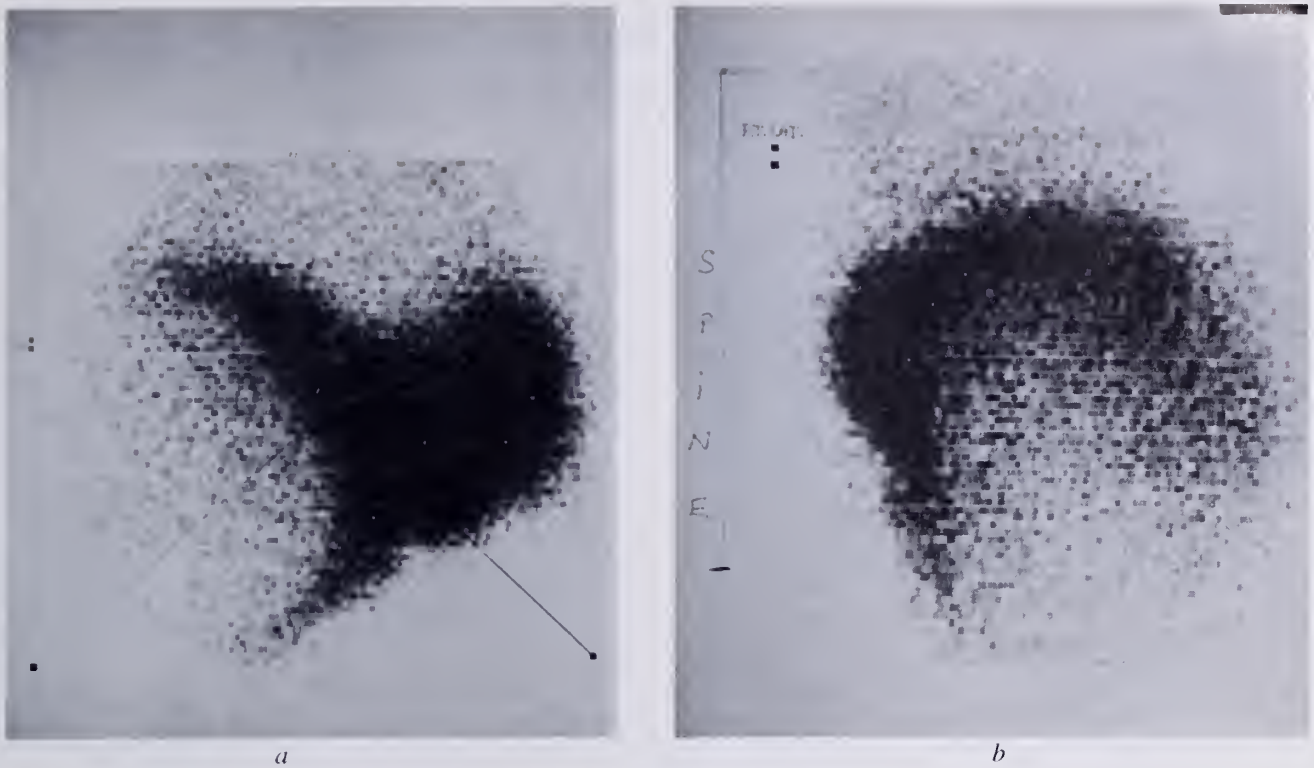
Case Report

C. W., a 33-year-old black female, was seen in the ER a few hours after she had been involved in an automobile accident. She was found to have pain in the neck, upper back and abdomen, with multiple contusions and abrasions. Films of the chest, cervicothoracic spine and abdomen were normal. After a short period of observation, she was allowed to go home. She did well until about two days later, when she began to develop severe pain in the right upper quadrant of her abdomen. On the third day she returned and was found to be in distress, with extreme tenderness in the right upper quadrant, so that palpation of the abdomen was difficult. Her conjunctivae were noted to be quite pale. Her blood pressure was 100/70, pulse 84 and temperature 100.6. The hemoglobin and hematocrit were 9.6 and 29, respectively. A stat recumbent film of the abdomen (see Figure 1) revealed that a large mass had appeared in the right upper quadrant since the film made three days earlier. This mass was displacing the hepatic flexure and transverse colon inferiorly. At this point a hematoma of either the liver or kidney was suspected. A peritoneal tap was negative. An excretory urogram (not shown) revealed moderate extrinsic compression of the right kidney in its anteroposterior dimension. A Tc-99m sulfur colloid liver scan was then performed. The anterior and lateral views (see Figures 2a and 2b) revealed a large area of diminished uptake in the anterolateral aspect of the right lobe of the liver. A subcapsular hematoma of the liver was then considered to be present. However, it was elected to perform hepatic arteriography to aid in ruling out major vascular damage or any underlying disease such as a liver



Figure 1. AP recumbent film of the abdomen revealing a large mass in the right upper quadrant displacing the colon inferiorly.

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a *b*

Figure 2. Anterior (a) and lateral (b) views from a Tc-99m sulfur colloid liver scan showing a large defect in the anterolateral aspect of the right lobe of the liver.

neoplasm. A frame from the selective hepatic arteriogram (see Figure 3) indicated a large, avascular mass in the anterolateral aspect of the right lobe of the liver, producing splaying and stretching of peripheral branches of the hepatic artery and medial displacement of the central branches. At laparotomy a large hematoma was identified beneath Glisson's capsule, involving the right lobe of the liver and displacing the liver. Approximately 800 cc. of liquid blood and 400 cc. of clotted blood were evacuated, representing a partially necrotic hematoma. There was no evidence of any deep-seated laceration. The surgeon's impression was that the bleeding was more of venous than arterial origin. There was suspicion that underlying liver disease or a clotting disorder was present, but this could not be confirmed by laboratory studies. The patient made an uneventful recovery.

Comment

Radionuclide scanning of the liver and spleen has proved to be a simple and rapid method of diagnosing liver laceration and hematoma formation. Scanning is also useful in following postoperative patients after repair of hepatic damage and in following small subcapsular hematomas which are being conservatively managed. The diagnosis of a subcapsular hematoma is suggested by the presence of a peripheral, pancake-like defect on the scan. Lacerations often produce linear defects and intrahepatic bleeding produces more central defects. Although the scan is sensitive in detecting liver injuries, the low specificity of this test generally does not allow determination of whether the liver capsule is torn or whether vascular damage is major or minor.

On the other hand, selective hepatic arteriography has been shown to be a highly specific method of evaluating the type and extent of hepatic injury. This is important because even at laparotomy it is frequently difficult to fully evaluate the extent of injury. Subcapsular hematoma has been described angiographically as an avascular area with regional vessels being elongated over the hematoma, while the central hepatic artery branches are displaced toward the hilus. Intraparenchymal hematoma, hepatic contusion and hepatic laceration likewise generally exhibit distinguishing features.

Summary

Three days after an episode of blunt abdominal trauma, a 33-year-old black female developed a painful right upper quadrant mass and anemia due to



Figure 3. Frame from the selective hepatic arteriogram revealing peripheral hepatic artery vessels elongated over the mass, with medial displacement of central vessels.

a large subcapsular hematoma of the liver. The clinical, radiographic and scintigraphic features are described together with findings at surgery. ★★★

3311 I-20 Frontage Road (39180)

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Brookings Predicts Deficit From NHI

The prestigious Brookings Institution, in a document entitled "Setting National Priorities," predicts that President Carter will not be able to carry out his proposed tax cuts while living up to costly campaign promises for various programs — including national health insurance.

Brookings suggests that a choice will be necessary because there will not be enough money to finance both without causing grievous harm to a highly inflationary economy.

Brookings says in its 319-page analysis that the new fiscal 1979 federal budget will make a deficit "a certainty" in fiscal 1981 and leave "no room for" the second round of major tax cuts Carter has hinted at for that year. If present plans are followed, the institution says, Carter is likely to end up with a $15-to-$30 billion deficit in fiscal 1981 rather than the small surplus he had projected. Most proposed NHI bills now being discussed cost as much or more to finance than the predicted deficit would be.

The Brookings projections underscore what many economists have cited as "inherent conflicts" among Carter's major budgetary goals.

Mississippi State Medical Association Auxiliary

Why AMA-ERF?

As you are probably aware, the cost of providing medical education and supporting research in the medical institutions of this country is staggering. Increasing the supply of physicians, improving the quality of medical education, and mounting new programs of medical research often means providing larger and better facilities, more equipment and additional faculty. Even schools with substantial endowments lack the funds to meet new requirements. Because of spiraling costs and shrinking government subsidies, their financial problems have been compounded. Consequently, these institutions must depend increasingly on private sources to meet their needs.

The American Medical Association-Education and Research Foundation, a non-profit organization, was established in response to these pressing needs. AMA-ERF is engaged principally in supporting medical education; providing financial assistance to medical students, interns, and residents; fostering scientific and medical research; and providing funds for rural and community-oriented pilot health projects.

The work of the AMA-ERF is made possible through the generosity of individual contributors. We are proud of the fact that approximately two-thirds of its income is derived from concerned physicians and the efforts of their wives in the AMA auxiliary. In an interview, Dr. Norman C. Nelson, Vice-Chancellor for Health Affairs at the University of Mississippi, expressed his appreciation for AMA-ERF monies: alterations in library for the placement of audiovisual aids, tape recorders and tapes on the sciences, summer research programs for students, anatomical models, guest lecturers, cassettes, establishment of a $15,000.00 loan program. Last year through your generosity and that of contributing auxiliaries, $14,818.99 was received from AMA-ERF.

Of all the many worthy causes to which you can contribute, few can match AMA-ERF in providing such lasting and important benefits. And you, through your gift can make a significant contribution in helping AMA-ERF achieve its primary goal; continued progress and excellence in medical education and research.

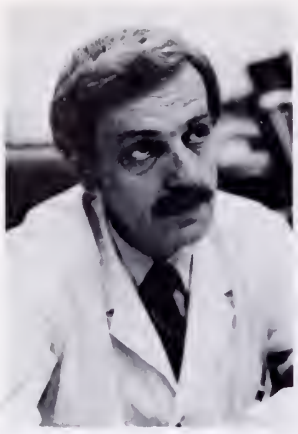
Please complete the form below and mail it with your check (payable to AMA-ERF). You may specify that the contribution go to the medical school of your choice or to the Loan Guarantee Program. Please support your local auxiliary's fund-raising events! Let's at least double the amount given last year. We can do it because the need is so great!

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☐ Loan Guarantee Program

Mail to: Mrs. Alvin E. Brent, Jr.
AMA-ERF State Chairman
2668 Lake Circle
Jackson, Mississippi 39211



The President Speaking

A Professional and Public Consensus on Health

CARL G. EVERS, M.D.
Jackson, Mississippi

Based on a preliminary analysis of responses from physicians in our state, preventive medicine is the most pressing health need among medical patients.

The responses have been received in connection with an MSMA project to address Mississippi's health needs. The project was directed by the House of Delegates at the recent 110th Annual Session.

In addition to an independent public opinion poll on health care which is presently being conducted, we are also polling the 1,700 members of the association as to what health needs they see in their practices. Have you responded? If not, I would urge you to do so.

An overwhelming number of the responses received thus far indicates great concern about the number of patients seen with preventable conditions, particularly heart disease and cancer. Obesity, alcohol and smoking are mentioned as prime causes of these preventable conditions.

Preventive health measures in the form of better health education of our children, better patient education and more preventable health services, have been stressed as the number one health need in our state.

On what might be classified as the treatment ledger of the poll, MSMA members have also strongly indicated their view that maternal and child care resources in our state need to be better planned and greatly improved. This is particularly indicated with respect to the apparent great number of mothers and children in our state who have no health insurance coverage and are also, for one reason or another, not eligible for Medicaid. Medicaid apparently complicates the problem for those who are covered by not adequately meeting the cost of private maternal and child care resources in our state.

In other areas of medical care concern the need for more primary care physicians in certain areas of our state has been identified as has inadequate transportation facilities. Concern has also been expressed about the methods and results of home health care services. Apparently some home health care agencies now compete among themselves to the point of soliciting patients and providing unnecessary services.

Interestingly, it appears that most of the concerns expressed in our MSMA poll thus far are also concerns of our patients — the public. A call to better emphasize preventive health measures recently showed up in a national poll of both the public and health professionals. Additionally, although the public, along with the medical profession, has not bought the idea of a federal health insurance program for all regardless of need, there has been a consensus on the need for some type of catastrophic coverage for all through a federally funded mechanism based on financial need and administered by private insurance companies. There has also been public recognition of the need for some type of third-party coverage of the poor who are presently either uncovered by any program or inadequately covered.

The present focus for public and professional decision making on health needs and health care is organized under Public Law 93-641, the National Health Planning and Resources Development Act of 1974. In Mississippi we have had good reason to question just what benefits can possibly evolve out of implementation of Public Law 93-641. Perhaps the answer lies in recognizing that apparently most of the concerns of our profession with respect to health needs and health care are also concerns of the public. ★★★

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EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

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Continuing Medical Education

As an incentive to members of the health profession to keep abreast of new developments and maintain high standards of excellence, many societies are instituting required CME. While the real value of such programs is yet to be determined, many local state and specialty societies are jumping on the CME bandwagon.

This increase in CME activities has prompted widespread development of programs offering opportunities for fulfilling CME requirements. Many are excellent programs, developed and presented in a manner conducive to learning important facets and facts applicable to patient care, office management, and hospital practice. These are the programs offered by the various societies, specialty groups, and educational centers. In contrast, there are many poorly planned and presented programs appearing on the CME scene. While these may fulfill the requirements of particular societies, they are costly to the physician in time and money and are of little value in upgrading his professional qualifications. In short, they are a waste of the physician's valuable time and finances.

MSMA members are urged to evaluate CME programs critically, whether they be formal meetings, seminars, or audiovisual presentations.

MYRON W. LOCKEY, M.D.
Associate Editor
Jackson, MS

Medico-Legal Brief

Subpoenas for Hospital Committee's Records Not Enforceable

Maryland's Commission on Medical Discipline was not entitled to enforce subpoenas it issued for records of a hospital review committee, a Maryland appellate court ruled.

The hospital review committee held a hearing to evaluate the qualifications, competence and performance of a certain physician. The hearing was not concluded and no decision was made. About a year and a half later the disciplinary commission began an investigation of a complaint about the physician's medical practices. The commission issued subpoenas to two physicians and ordered them to bring records of the hospital review committee. The physicians refused to comply with the subpoena, and the commission filed suit to enforce them. A trial court ordered the subpoenas enforced, and the physicians appealed.

Reversing the order of enforcement, the appellate court said that the disciplinary action was not a civil action in which the commission was barred from issuing a subpoena. However, a statute enacted eight weeks after the trial court's order expressly provided that no minutes or notes taken during a hospital's review of a physician's privileges were discoverable. The court said that the trial court's order to produce records of the hospital review committee was too broad since there was no exclusion of minutes or notes.

The trial court's order was reversed and the case remanded for further proceedings. — *Cocco v. Maryland Commission on Medical Discipline,* 384 A.2d 766 (Md. Ct. of Special Apps., April 12, 1978)

LETTERS

SIRS: The Mississippi Epidemiologic Studies Program (MS ESP) is in need of assistance from physicians in Mississippi, Alabama, Tennessee, and Kentucky. Our project, located at the State Chemical Laboratory on the Mississippi State University campus, is responsible for implementing the *Pesticide Incident Monitoring System* (PIMS) in our geographical region which includes Alabama, Kentucky, Tennessee, and Mississippi. The study is part of a nationwide effort to determine the effects of pesticides on human health and the environment.

The national program is being conducted by 13 epidemiologic studies programs, all of which operate under contract with the Environmental Protection Agency, Office of Pesticide Programs, Human Effects Monitoring Branch.

The PIMS is designed to be a totally voluntary reporting system, and it is hoped that all pesticide related incidents will be accounted for and documented. We feel the request is not unreasonable since the number of poisoning cases seen by any one physician is relatively small. We also emphasize that a patient's identity is not needed since we are interested only in the pertinent facts surrounding a poisoning incident: time, place, pesticide involved, occupational relationship, route of exposure, major symptoms exhibited, and type medical treatment administered. Information is requested on all pesticide related cases including acute, subacute, and chronic exposure.

As a service, the MS ESP offers the laboratory's expertise in dealing with pesticide poisonings. We provide free cholinesterase determinations and pesticide residue analyses to aid in the diagnosis and confirmation of poison cases. Due to the time and distances involved, these analyses would most likely be performed as confirmatory aids and not in the actual diagnoses. For more information on the MS ESP in general and the PIMS in particular, write or call me at the address below.

We will gladly furnish you with poison information forms, which are concise and require little time for completion and a copy of *Recognition and Management of Pesticide Poisonings*. Forms have already been mailed to all general care hospitals in our area of responsibility. We hope that very few pesticide poisonings occur in your area, but if they do, we sincerely request that all incidents be reported for the period January-December 1978.

Dr. Larry G. Lane
Mississippi Epidemiologic Studies Program
Mississippi State Chemical Laboratory
Box CR
Mississippi State, MS 39762
Phone — (601) 325-4308

Sirs: Two new studies compare fundamentally different approaches for the provision of government-financed outpatient drug programs in Texas and California. Of particular interest are the results achieved by the two programs and the implications that they have for public policy. They are as follows:

—The Texas Medicaid drug program, emphasizing control of utilization and fraud while making all drugs available to Medicaid patients, has shown superior results in controlling Medicaid drug-expenditure growth.

—The California program, which concentrates on drug-price restrictions and limited choice of drugs, fails to address the real problem of increased utilization and even proves counterproductive in controlling overall product (ingredient) price increases.

—In Medi-Cal, the ingredient prices of products covered by its price-cap scheme (MAIC) rose 28.6 per cent during the study period, while single-source drugs not under unit-price controls in the same program rose only 15.6 per cent. The overall ingredient price growth in the Medi-Cal drug program was 20.2 per cent, as compared with the market-disciplined Texas Medicaid unit-price growth of only 9.9 per cent.

—Texas's market-oriented system clearly outperformed, by a factor of two to one, California's highly restrictive and regulated price-control system. This provides additional insight into policy considerations relevant to public programs with weakened financial constraints on providers and/or recipients.

—A Harris opinion poll of Medicaid populations of both Texas and California reveals that recipients and taxpayers are equally pleased with their respective Medicaid drug programs, and there is more general public support for the total Medicaid program in Texas than in California.

I trust that this material will be of interest to you. If you wish further information, please feel free to contact me at (317) 261-2860.

Thomas F. Olsen, Manager
Corporate Affairs Research
Eli Lilly and Company
Indianapolis, IN 46206

THE LITERATURE

Book Review

Sniff, Sniff, AL-ER-GEE. By Claude A. Frazier, M.D. Published by Johnny Reads, Inc., St. Petersburg, FL, 1978, for ages 4-8. $2.65 paperback.

I like the book *Sniff, Sniff, AL-ER-GEE* because it teaches you things about allergies, before you go to the doctor. The book has easy words so you can read

it easily. This book helps you to get prepared for what the allergist is going to do to you. I also like *Sniff, Sniff, AL-ER-GEE* because it has very good illustrations.

I don't like *Sniff, Sniff, AL-ER-GEE* because the illustrations aren't colorful and there is so much in the back for the parents. I think it could have been shorter and not have so many words.

Those are the only major dislikes that I could find about *Sniff, Sniff, AL-ER-GEE*. I really enjoyed this book. I'm ready now.

SALLY KAY MITCHELL
(Age 10)
Jackson, MS

(EDITOR'S NOTE: Because this book was written for children in physicians' waiting rooms, the JOURNAL elected to have a child who is an allergy patient review the book. Sally Kay is the daughter of Dr. and Mrs. Don Q. Mitchell.)

DEATHS

HEWES, A. C., Gulfport. Born Gulfport, MS, June 14, 1906; M.D., Vanderbilt University School of Medicine, Nashville, TN, 1930; interned Charity Hospital, New Orleans, LA, one year; surgery residency, Strong Memorial Hospital, Rochester, MN, 1931-32; surgery residency, St. Agnes Memorial Hospital, Baltimore, MD, 1932-33; died July 27, 1978, age 73.

SMITHSON, WILLIAM A., Jackson. Born Goodman, MS, Sept. 6, 1916; M.D., University of Tennessee School of Medicine, Memphis, 1940; interned St. Joseph Hospital, Memphis, one year; ob-gyn residency, John Gaston Hospital, Memphis, TN, 1942-43; died Aug. 15, 1978, age 61.

NEW MEMBERS

ASEME, KATE N., Hattiesburg. Born Nigeria, Nov. 20, 1944; M.D., Howard University College of Medicine, Washington, D.C., 1970; interned Harlem Hospital, New York City, one year; surgery residency, same, 1970-73; surgery residency, Harlem Hospital and Columbia Presbyterian Hospitals, 1974-77; elected by South Mississippi Medical Society.

BURROW, WILLIAM HOLLIS, II, Jackson. Born Walla Walla, WA, Nov. 19, 1945; M.D., University of Mississippi School of Medicine, Jackson, 1973; interned UMC, Jackson, MS, one year; dermatology residency, University of Alabama Hospital, Birmingham, 1974-77; elected by Central Medical Society.

CARR, THOMAS MARTIN, Tupelo. Born Memphis, TN, Dec. 21, 1947; M.D., University of Mississippi School of Medicine, Jackson, 1974; interned UMC, Jackson, MS, one year; internal medicine residency, same, 1975-77; elected by Northeast Mississippi Medical Society.

COCKRELL, MARION E., JR., Biloxi. Born West Point, MS, July 14, 1937; M.D., Tulane University School of Medicine, New Orleans, LA, 1962; interned Charity Hospital, New Orleans, one year; ob-gyn residency, same, 1963-66; elected by Singing River Medical Society.

COLLIER, RICHARD E., JR., Oxford. Born Nashville, TN, Aug. 23, 1946; M.D., University of Tennessee School of Medicine, Memphis, 1972; interned Baptist Memorial Hospital, Memphis, one year; surgery residency, same, 1973-77; elected by North Mississippi Medical Society.

COOPER, ROBERT F., III., Oxford. Born New Orleans, LA, July 27, 1951; M.D., University of Mississippi School of Medicine, Jackson, 1976; interned Baptist Memorial Hospital, Memphis, TN, one year; elected by North Mississippi Medical Society.

DIAZ, ALBERT L., Ocean Springs. Born New Orleans, LA, Sept. 29, 1939; M.D., Facultad de Medicina de la Universidad Nacional Autonoma de Mexico, Mexico, 1971; interned Toledo Hospital, Toledo, OH, one year; ob-gyn residency, Medical College of Ohio, Toledo, 1972-73; ob-gyn residency, William Beaumont Hospital, Royal Oak, MI, 1973-75; elected by Singing River Medical Society.

GOFF, JAN T., Tupelo. Born Tampa, FL, July 15, 1936; M.D., St. Louis University School of Medicine, St. Louis, MO, 1961; interned Jewish Hospital, St. Louis, one year; psychiatry residency, 1962-65; elected by Northeast Mississippi Medical Society.

HAMILTON, JIMMY LYNN, Tupelo. Born Pine Bluff, AR, Oct. 29, 1946; M.D., University of Mississippi School of Medicine, Jackson, 1972; interned University Hospital, Jackson, MS, one year; surgery residency, same, 1973-77; fellowship in vascular surgery, same, 1977-78; elected by Northeast Mississippi Medical Society.

KIM, ACHIN, Starkville. Born Korea, Aug. 15, 1943; M.D., Korea University Medical School,

NEW MEMBERS / Continued

Seoul, 1967; interned Lutheran Medical Center, Brooklyn, NY, 1968-69; internal medicine residency, Wilmington Medical Center, Wilmington, DE, 1969-73; internal medicine residency, Thomas Jefferson University Hospital, Philadelphia, PA 1977; elected by Prairie Medical Society.

PROFILET, WILLIAM B., JR., Ocean Springs. Born Greenville, MS, Mar. 25, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1969; interned UMC, Jackson, MS, one year; ob-gyn residency, National Naval Medical Center, Bethesda, MD, 1972-75; elected by Singing River Medical Society.

ROSS, SIDNEY O., JR., McComb. Born Harrisville, MS, May 26, 1939; M.D., Louisiana State University School of Medicine, New Orleans, 1972; interned UMC, Jackson, MS, one year; surgery residency, Charity Hospital, New Orleans, 1973-77; elected by South Central Medical Society.

PERSONALS

JOHN K. ABIDE of Cleveland announces the association of LANCE D. WHALEY for the practice of obstetrics and gynecology at Delta Medical Clinic, 801 1st Street.

HANS W. ADAMS announces the opening of his office for the practice of gastroenterology at Coastal Medical Center, Gateway Executive Park in Biloxi.

ROBERT E. AIKEN has been added to the staff of emergency room physicians at Gulf Coast Community Hospital. Dr. Aiken, retired from the U. S. Army, is a California native but now resides in Gulfport.

LOUIS A. BENOIST announces the opening of his practice in orthopedic surgery at 1020 Biglane Drive in Brookhaven.

GREGORY BERTUCCI has joined the staff of the Eye, Ear, Nose and Throat Hospital in Gulfport as an ophthalmologist at 3017 13th Street.

T. D. BLANTON and JOHN P. MURRAY of Jackson announce the opening of their clinic for diseases of the ear, nose and throat at 7 Lakeland Circle, Suite 100.

DARRELL N. BLAYLOCK is now serving as consultant physician in tuberculosis and other pulmonary diseases for the Tuberculosis Control Unit's Regional Hospital Program at the Delta Medical Center in Greenville.

JAMES L. BROWN announces the opening of his office for the practice of internal medicine at 420 Magazine Street in Tupelo.

JOHN C. CLAY and THOMAS D. CROWSON announce the opening of their office for the practice of gastroenterology (Dr. Crowson), hematology-oncology (Dr. Clay) and internal medicine at Internal Medicine Specialties Clinic, 1219 22nd Avenue in Meridian.

ROBERT L. COGGIN and JAMES W. FITE of Grenada announce the relocation of Children's Clinic of Grenada, P.A., to Grenada County Hospital Physicians' Office Building, 965 Avent Drive.

DALE R. DUNNIHOO of Ocean Springs has joined the Bosco-Henneberger-DiSanti Woman's Clinic in Pascagoula for the practice of obstetrics and gynecology. Dr. Dunnihoo recently retired from the Air Force.

The Field Clinic of Centreville announces the association of JOHN B. FLOOD for the practice of family medicine.

HANLEY E. HASSELTINE announces the opening of his office for the practice of ear, nose and throat surgery, facial plastic surgery and ENT allergy at Doctors Hospital Professional Building, 385 Medical Drive in Jackson.

BOBBY J. HEATH of Jackson announces the opening of his practice in cardiovascular and thoracic surgery at the University Medical Center, 2500 North State Street.

E. J. HOLDER, CLEVE E. JOHNSON, and THOMAS H. BLAKE, JR., of Laurel announce the association of EDWARD R. TURNBULL for the practice of orthopaedic surgery at the Laurel Bone and Joint Clinic, P.A., at 424 13th Avenue.

CHARLES M. HOLMAN, JR., has joined the medical staff at Howard Memorial Hospital in Biloxi for the practice of adult and pediatric urology. He is affiliated with ROBERT F. CARTER at 964 West Division Street.

MICHAEL JABALEY of Jackson and UMC attended a council meeting of the American Society for Surgery of the Hand in Denver during August.

HERBERT G. LANGFORD of Jackson and UMC participated in the International Symposium on Vascular Neuroeffector Mechanisms in London, England, and Louvain, Belgium.

JOHN PAUL LEE of Forest announces the association of THOMAS H. CABELL for the general practice of medicine at 285 East First Street.

LYNDA G. LEE of Moss Point was appointed County Health Officer by the Jackson County Board of Supervisors.

JOHN LEVENS of Waveland has been appointed to fill an unexpired term on the Bay-Waveland Municipal Separate School District board of trustees.

ROBERT ASHFORD LITTLE, Biloxi ophthalmologist, announces the relocation of his office from the Eye, Ear, Nose and Throat Hospital in Gulfport to the Coastal Medical Center Building, Gateway Executive Park, 4642 West Beach Boulevard in Biloxi.

KANWAL N. MANIKTAHLA, formerly of Grenada, has opened his offices in Batesville for the practice of urology.

ROBERT ODELL MAY of Jackson announces the relocation of his office from Hinds Professional Building to 1992 McDowell Road.

CORTEZ MCFARLAND and WESLEY PRATER announce the opening of the Metropolitan Obstetrics and Gynecology, P.A., for the practice of ob-gyn at 500-M East Woodrow Wilson Avenue in Jackson.

FRANCIS S. MORRISON of Jackson and UMC presented five papers at the International Society of Hematology meeting in Paris.

BEVERLY W. MYERS has opened her offices for the practice of internal medicine and rheumatology at 1213 Broad Avenue in Gulfport.

ROBERT P. MYERS announces the opening of his office in dermatology at Moore's Creek Office Plaza, Suite No. 3, 2102 Fifth Street North in Columbus.

ED NORTH of Jackson has been elected president-elect of the National Exchange Club.

J. TOM PEURIFOY, JR., has opened his practice of general and peripheral vascular surgery in the Coastal Medical Center in Biloxi.

WILLIAM J. REED has associated with Rush Medical Group, P.A., of Meridian for the practice of pediatrics, adolescent medicine and neonatology at 1314 19th Avenue.

D. C. STRANGE and T. S. PARVIN of Starkville announce the association of RAYMOND J. ORGLER for the practice of general and thoracic surgery at the Starkville Surgical Clinic, P.A., 106 Strange Road.

PATRICK E. TARPY has associated with McComb Children's Clinic, LTD for the practice of pediatrics at Medical Arts Building, 300 Rawls Drive.

C. D. TAYLOR, JR., of Pass Christian has been reappointed to a full term on the Pass Christian Housing Authority by the city's board of aldermen.

JOHN A. WIMBERLY of Gulfport announces the opening of his family practice at 1001 32nd Avenue.

JOHN R. YOUNG, JR., of Natchez announces the association of PAUL N. PETTIT, JR., in the practice of otorhinolaryngology, head and neck plastic surgery at the Ear, Nose and Throat Clinic, P.A., 55 Sgt. S. Prentiss Drive.

IVAN V. ZAMORA has joined The Medical Group of Quitman for the practice of general and vascular surgery.

POSTGRADUATE CALENDAR

Oct. 26-27, 1978
CLINICAL RHEUMATOLOGY
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Medicine Division of Rheumatology and the University Medical Center Division of Continuing Health Professional Education.

Coordinator: James B. Pennebaker, M.D., assistant professor of medicine and rheumatology division chief, University of Mississippi School of Medicine.

This seminar is designed to update the knowledge and clinical skill in rheumatic diseases for general practitioners and internists. Recent advances in diagnosis and treatment of rheumatic diseases will be discussed. A guest faculty will present the program. Partial funding is by the Upjohn Company. Fee: $35.00. Credit: 10 contact hours, .1 CEU, Category I, AMA; AAFP.

Nov. 10, 1978
UPDATE: PITUITARY SYMPOSIUM
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Neurosurgery, the Mississippi Neurosurgical Society and the University Medical Center Division of Continuing Health Professional Education.

Coordinators: Robert A. Sanford, M.D., assistant

professor of neurosurgery, and Robert R. Smith, M.D., professor of neurosurgery, University of Mississippi School of Medicine.

The symposium will focus on diagnosis and treatment of pituitary tumors. Clinical features and techniques used in the diagnosis of pituitary diseases will be reviewed and updated. The course is for endocrinologists, internists, radiologists, neurologists and neurosurgeons. Fee: $30.00. Credit: 6 contact hours, .6 CEU; Category I, AMA.

Nov. 10-12, 1978
FAMILY PRACTICE UPDATE
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Family Medicine and the University of Mississippi Medical Center Division of Continuing Health Professional Education.

Coordinator: Ian Cameron, M.D., assistant professor of family medicine, University of Mississippi School of Medicine.

This three-day course is offered as a refresher for primary care physicians. Discussions will cover new developments in patient care. Fee: $85.00. Credit: 18 contact hours, 1.8 CEU, Category I, AMA; AAFP.

FUTURE CALENDAR
Dec. 2, 1978
DIAGNOSIS, TREATMENT AND REHABILITATION OF PATIENTS WITH UPPER LIMB PROBLEMS
Methodist Rehabilitation Center, Jackson
All continuing education correspondence should be addressed to: Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State St., Jackson 39216.

Tulane Alumni Plan Homecoming

The Tulane Medical Alumni Association announces homecoming 1978 and the annual Medical Alumni Study Club and postgraduate courses Oct. 19-20 at the Tulane Medical Center in New Orleans.

Courses offered on Oct. 19 include programs on death and dying and a symposium in prenatal diagnosis of genetic disease. Class reunion dinners and the Study Club will be held on Oct. 20 and the general alumni dance will be that night.

For further information, contact Cindy Wright, TMAA Coordinator, 1430 Tulane Avenue, New Orleans, LA 70112.



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The Council on Scientific Assembly Plans 111th Annual Session, May 6-10, 1979

The Council on Scientific Assembly met at the MSMA headquarters office on September 7 to plan activities for the 111th Annual Session of the association which is set for May 6-10, 1979, at Biloxi.

According to council chairman, Dr. J. Elmer Nix of Jackson, the 14 scientific sections will meet on Sunday, Tuesday and Wednesday of convention week. The association's policy-making body, the House of Delegates, will conduct meetings on Monday and Thursday mornings. Monday afternoon will be the reference committee meetings and the annual meeting of the Mississippi Foundation for Medical Care. The Mississippi Medical Fraternal and Educational Society (MMFES) will hold its annual meeting on Sunday afternoon.

The council added two new attractions to next year's annual meeting. Planned for Sunday afternoon is a seminar for physicians on practice management and productivity. An additional feature on Tuesday morning will be a special general interest presentation on scoliosis screening.

The MSMA President's Reception will be held Sunday evening and Ole Miss, Tulane, Tennessee and LSU alumni occasions will take place on Monday evening. The annual association cocktail party/exhibitors' reception is set for Tuesday evening. Wednesday evening was left free for convention attendees to enjoy the dining and recreational facilities on the Gulf Coast.

The association will again sponsor a tennis tournament in conjunction with the annual session. A chairman and details for pre-registration will be published in the JOURNAL at a later date.

The MSMA Auxiliary will meet concurrently during the MSMA annual session and will again plan and staff the Sunday afternoon hospitality and welcome booth.

The prospectus for technical exhibitors has been mailed and applications for scientific exhibit space will go out to prospective exhibitors after the first of the year. Invitations to specialty societies to meet during convention week have also been sent.

Schedule for the 14 scientific section meetings is as follows: Sunday, May 6 — sections on pathology, orthopedic surgery, anesthesiology and psychiatry; Tuesday, May 8 — sections on medicine, radiology, surgery and pediatrics; and Wednesday, May 9 — sections on ob-gyn, family practice, EENT, preventive medicine, urology and dermatology.

The convention will end at noon on Thursday, May 10.

SBH Issues Physician Advisory On Health Effects of Asbestos

The results of recent studies of shipyard workers have increased concern about the health effects associated with previous occupational exposure to asbestos. This advisory notice will assist you in dealing with inquiries from your patients and other members of the public.

Asbestos refers to a group of widely used fibrous minerals. Significant exposure of men and women employed in shipyards is known to have occurred, even among those not directly working with asbestos. Exposure to asbestos can also occur in many settings, such as, direct mining and manufacturing; construction, insulation; roofing; demolition; brake lining; and the manufacture and installation of asbestos pipe, sheets, panels, paper products, friction materials, textiles, floor tiles, paints, and gaskets. The risk has been documented extensively for certain occupational exposures, and there are reports that asbestos-associated disease also occurs in household contacts of asbestos workers.

The primary effects of past asbestos exposure are asbestosis, a lung disease, and certain types of cancer, primarily lung cancer and pleural and peritoneal mesothelioma and, less frequently, gastrointestinal and other cancers. It is now known that the health effects of asbestos appear after a long latent period (15, 25, 35 or more years) after the initial exposure. Exposures as short as a month may result in disease many years later, because the in-

haled dust, being mineral, tends to remain in the tissues. It has been noted in studies of heavily exposed workers that approximately 20 to 25 of each 100 deaths among asbestos workers 20 or more years from onset of exposure are found to be from lung cancer, 7 to 10 from mesothelioma, 4 from cancer of the esophagus, stomach, colon/rectum, and some excess cancers of other sites (oropharynx, larynx, and kidney). In addition, in some groups, as many as 7 per cent of workers die of a form of pneumonoconiosis, asbestosis. Cigarette smoking significantly increases the lung cancer risk of asbestos exposure and aggravates asbestosis.

In dealing with your patients or other individuals who worked in shipyards or believe that they were otherwise exposed to asbestos, you may wish to consider the following issues:

1. *Occupational or Exposure History* — A detailed, lifetime history must be obtained. This is time consuming, but important because significant exposures may have been brief (one month) and may have occurred many years ago (i.e., during World War II). Because the World War II work force was comprised of many women as well as men, the potential for female patient involvement should not be overlooked.
2. *Careful Management of Lung Disease* — A detailed history for symptoms such as shortness of breath or exertional dyspnea, physical examination, chest x-ray, and pulmonary function tests may be helpful in diagnosing the pneumonoconioses associated with asbestos. Early x-ray changes are often subtle so x-ray must be reviewed carefully by experienced readers. Such readings should include a thorough search for pleural changes. Careful attention to and aggressive treatment of respiratory infections may be important in patients with asbestosis. The use of currently effective influenza and pneumococcal vaccines should be considered.
3. *Emphasis on Smoking Cessation* — Discontinuation of smoking is an important step in the control of the sequelae of asbestosis and will assist in the prevention of lung cancer. Individuals who smoke and who have been exposed to asbestos have 30 to 90 times the risk of getting lung cancer of individuals who neither smoke or have been exposed to asbestos and 7½ to 30 times the risk of the non-smoking asbestos workers. Data are available which show that cessation of smoking will significantly diminish the risk of developing lung cancer among asbestos workers.

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Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

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Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors. (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

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Direct Medical Inquiries to
MERRELL-NATIONAL LABORATORIES
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References: 1. Citations available on request — Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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Whether overweight is a complicating factor... or just uncomplicated overweight.

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75 mg. controlled-release tablets



A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with hypertension, symptomatic cardiovascular disease, or diabetes. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. (Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.)

In uncomplicated obesity.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorexic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorexic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

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Injection, 300 mg./2 ml., in single-dose vials in packages of 10.

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4. *Cancer Surveillance* — The usefulness of screening asymptomatic, exposed individuals for lung, gastrointestinal and other cancers is now under study in clinical trials. Individuals, however, should be carefully questioned regarding possible symptoms which could be related to cancer: chest pain, hoarseness, hemoptysis, weight loss, melena, etc. If such symptoms are present, an appropriate diagnostic workup should be undertaken.

It is important ot note that many people exposed to asbestos — perhaps a majority — suffer no apparent ill effects. It is hoped that most of your patients will be in this category.

Current use of asbestos is regulated, but attention must be given to proper ventilation and engineering controls and the use of respirators — all measures of primary prevention. In the past the dangers of asbestos exposure were not fully appreciated; much exposure occurred in previous decades, particularly in shipyards, where individuals often worked in confined quarters.

UMC Schedules Clinical Rheumatology Seminar

The University of Mississippi Medical Center will sponsor a clinical rheumatology seminar Oct. 26-27.

Dr. James B. Pennebaker, assistant professor of medicine and director of the UMC rheumatology division, is coordinator. The seminar is sponsored by the UMC School of Medicine Department of Medicine Division of Rheumatology and the UMC Division of Continuing Health Professional Education.

Guest faculty includes Dr. Werner F. Barth, chairman of the rheumatology section at Washington (DC) Hospital Center and professor of medicine, George Washington University; Dr. Andrei Calin, assistant professor of medicine at Stanford University and chief of the arthritis section at VA Hospital in Palo Alto; and Dr. David S. Howell, professor of medicine and director of the arthritis division, University of Miami School of Medicine.

Also, Dr. Frederic C. McDuffie, a former UMC faculty member who is now professor of medicine and immunology and director of the rheumatology research laboratory, Mayo Medical School; and Dr. Lawrence E. Shulman, associate director for arthritis, bone and skin diseases, National Institutes of Health.

Course fee is $35.00. Credit is 10 contact hours. For more information, contact Continuing Education at the Medical Center.

UMC Now Has Blood Cell Separator

A new method of treatment, called pheresis, is available at the University of Mississippi Medical Center. The technique removed 40 pounds of leukemic cells from a single patient over a six-month period.

Dr. Francis Morrison, professor of medicine and hematology division director, said the patient's leukemia was kept under control without medication from the first trimester of pregnancy until delivery. The mother is in remission and the baby is healthy, Dr. Morrison said.

"The new technique can extract the total blood volume three times in three hours," he said.

At the Medical Center, the technique has also been used as emergency treatment for extremely high white counts before drugs have a chance to work. By removing blood platelets, pheresis has been helpful as a temporary measure while patients with thrombosis are also being treated with drugs. Symptomatic relief of myasthenia gravis has been obtained by replacing the patient's total plasma volume.

According to Dr. Morrison, patients with Goodpasture syndrome, glomeruli nephritis, lupus, and thrombotic thrombocytopenic purpura, and Reye's syndrome respond dramatically to treatment with the separator, often requiring no further treatment.

"Despite the good results we've had so far, all applications are still experimental and further studies are ongoing and essential," Dr. Morrison noted.

The new blood cell separator is one of only five of its kind in the country.

Family Medicine Workshop Held at UMC



Among the guest faculty for the University of Mississippi Medical Center seminar on family medicine teaching were Dr. Frank Stritter, center, and Dr. Richard Baker, right, both of the University of North Carolina in Chapel Hill. Dr. Stritter is associate professor of medicine, education and public health, and Dr. Baker is associate professor of family medicine. Dr. T. Walter Treadwell, left, UMC associate professor of family medicine, coordinated the workshop.

CME Accreditation Growth Is Reported

MSMA's Council on Medical Education has announced that 14 Mississippi hospitals and medical societies are now accredited as sources for physicians' continuing medical education.

The council, which serves as an arm of the Liaison Committee on Continuing Medical Education in Chicago for accrediting Mississippi hospitals and medical societies offering CME to physicians, reports a growing increase in interest among medical organizations in the state toward seeking accreditation. In addition to the 14 accredited organizations, some eight other organizations are presently in various stages of seeking accreditation.

Full details and instructions on seeking accreditation may be obtained by writing the MSMA Council on Medical Education, Box 5229, Jackson 39216.

Abbott Labs Honors Dr. Van Dyke Hagaman

Abbott Laboratories of North Chicago, IL, recently honored Dr. A. Van Dyke Hagaman of Jackson for his many years of dedicated medical service to the residents of Mississippi.

He was presented a Jefferson Gold Hour Clock by Dave Smith, Abbott Labs area professional medical representative.

Dr. Hagaman, an EENT specialist, is a 1928 graduate of Vanderbilt University. He has practiced medicine for more than 50 years and continues to practice at 1151 North State Street in Jackson.



Dr. Hagaman, at right, receives the Golden Hour Clock from Dave Smith, Abbott Labs representative.

Forrest General Announces CME Seminar

Forrest General Hospital in cooperation with the Hattiesburg Clinic Professional Association will conduct its 2nd Annual CME Seminar on Nov. 30, 1978.

The seminar entitled "Cerebral Vascular Disease Update" is open to all interested physicians. Speakers will include Dr. Charles R. Crane, associate director, Department of Physical Medicine, Baylor University; Dr. Albert Heck, professor and chairman, Department of Neurology, University of Tennessee; and Dr. Robert R. Smith, professor of neurosurgery, University of Mississippi School of Medicine. Local faculty will include Drs. Kenneth J. Graves, Carl R. Hale, Gerald Robertson and Ralph Wicker, all of Hattiesburg.

Further information may be obtained by writing Dr. David M. Owen, 415 S. 28th Avenue, Hattiesburg 39401. There is no registration fee.

Medical Center Announces Faculty Additions

Two assistant professors have joined the School of Medicine faculty at the University of Mississippi Medical Center in Jackson.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced the new appointments following approval by the Board of Trustees, Institutions of Higher Learning.

Named to the medical school faculty are Dr. Eliezar Moshe Izsak, assistant professor of medicine, and Dr. Sylvia Shellenberger, assistant professor of family medicine (educational psychology).

Dr. Izsak earned the M.D. degree at the University of Toronto School of Medicine. He interned at Wellesley Hospital, and took residency training at Sunnybrook, Mount Sinai and Toronto General Hospitals, all in Toronto.

A school psychologist in the Tempe (Ariz.) school districts since 1977, Dr. Shellenberger earned the B.S. and M.S. degrees at Millersville (Pa.) State College. She earned the Ph.D. degree at the University of Georgia.

Pituitary Tumor Conference Is Planned at UMC

Diagnosis and management of pituitary tumors will be discussed during a Nov. 10 seminar at the University of Mississippi Medical Center in Jackson.

Sponsored by the UMC School of Medicine Department of Neurosurgery and the UMC Division of Continuing Health Professional Education, the course is coordinated by Dr. Robert A. Sanford, assistant professor of neurosurgery, and Dr. Robert R. Smith, professor of neurosurgery.

Dr. Peter O. Kholer, professor of medicine and department chairman at the University of Arkansas Medical School, and Dr. Donald P. Becker, professor of neurosurgery at the Medical College of Virginia, are guest faculty.

Course fee is $30.00. The seminar carries 8.5 contact hours credit. Further information may be obtained from Continuing Health Professional Education, University Medical Center, 2500 North State Street, Jackson, MS 39216.

A Boston Tea Party Is Urged

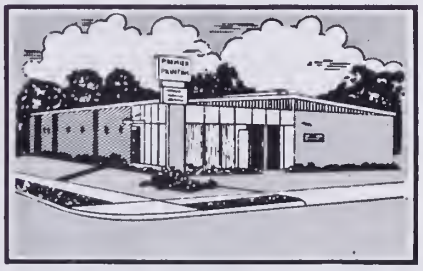
The American Conservative Union has launched an interesting campaign to stimulate members of Congress toward tax deductions.

Representative Phillip Crane, Republican of Illinois and ACU chairman, urges all disenchanted taxpayers to mail a tea bag to any government official who they feel is squandering excessive amounts of taxpayer funds.

The ACU is also directing a national effort to amend the federal constitution and limit federal spending.

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Index to Advertisers

Bryant Bureau 7
Burroughs Wellcome Co. 8

Canton Exchange Bank 7
Citizens Bank & Trust Co. 11

Disability Determination Services 11

Guaranty Properties 10

Harreld Chevrolet-Oldsmobile 188
Hill Crest Hospital 196

Eli Lilly and Co. 12

Mead Johnson Pharmaceutical Division 190A, 190B
Merrell-National, Inc. **14B, 15, 16,** 198, 198A

Parke, Davis and Co. 18
Premier Printing Co. 19

Richardson-Merrell, Inc. 6B
Riverside Hospital 3
Roche Laboratories
..... **second cover, 6, 6A, third and fourth covers**

Roerig and Co. **14, 14A**

Smith Kline and French 198B
E. R. Squibb and Sons **10A, 10B**

The Upjohn Company 17

Thomas Yates and Co. 4

IN CONCLUSION

Health care providers and hospitals are widely respected and much more highly regarded than all other major private sector and governmental institutions, a Harris poll conducted for Hospital Affiliates International--the nation's largest hospital management firm--has found. The study included interviews with a national cross-section of 1,503 adults and representative samplings of physicians, hospital administrators and trustees, health insurance company executives, and congressmen on health-related committees.

A recently enacted Wisconsin statute prohibits hospitals which provide emergency services to refuse emergency treatment to any sick or injured person. Hospitals may not delay emergency treatment pending initiation of credit checks or financial information of the patient if, in the opinion of one of the specified agents, employees or staff members of the hospital, "the delay is likely to cause increased medical complications, permanent disability or death..." A hospital is not required to provide emergency services beyond its capabilities but must have a referral plan.

A new Certificate of Need (C.O.N.) Assistance Program is being offered to hospital administrators and the hospital community, announces Pfizer, Inc. A toll-free telephone consultation service, part of the Comprehensive Assistance Program, will offer hospital administrators direct access to expert consultation on medical needs and cost effectiveness of major diagnostic equipment, and relevance of this information to C.O.N. Pfizer also offers the complimentary book, "Certificate of Need: An Expanding Regulatory Concept," a comprehensive, state compilation of C.O.N. requirements.

The 10th Circuit Court of Appeals upheld a lower court injunction to prohibit FDA from interfering with procurement of laetrile for "intravenous injections administered by a licensed medical practitioner to persons who are certified by a licensed medical practitioner to be terminally ill of cancer in some form." Court did not reach the issue whether laetrile has satisfied safety and efficacy requirements of the Food, Drug and Cosmetic Act, but stated that such requirements had no meaning or application for terminally ill cancer patients.

MISCELLANEOUS: The U.S. Chamber of Commerce will launch a national action program on health, designed to help employers contain costs in their own communities. The basis for the program will be the National Chamber Foundation's health care study.....A study, sponsored by the U.S. Agriculture Department, indicates that cigarette smoking has dropped about 1% in 1977. The per capita figure for cigarettes was 4,064, slightly below 203 packs per person. In 1976, the average number smoked was 4,092.

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.



Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introital colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

November 1978

BALCONY

Journal of the State Medical Association

Mississippi



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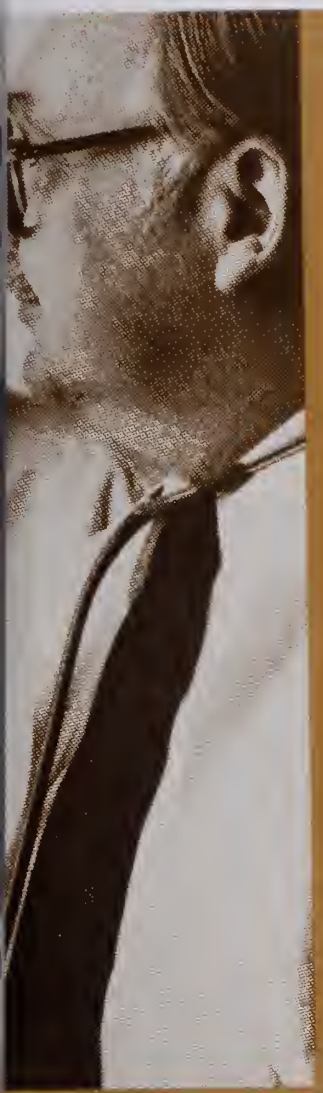


More than two decades of research—including hundreds of animal studies and hundreds of clinical trials—stand behind the proven antianxiety performance of Librium.

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safety record

What excited clinical researchers about Librium was its promise of effective antianxiety action within an unprecedented margin of safety. This promise continues to be fulfilled in millions of patients today— most likely including many of your own.



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- ☐ Minimal effect on mental acuity
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- ☐ Is used concomitantly with primary medications, such as anticholinergics and cardiovascular drugs

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5mg, 10mg, 25mg capsules

synonymous with relief of anxiety

Please see next page for summary of product information.

Librium® 5mg, 10mg, 25mg capsules
chlordiazepoxide HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema; minor menstrual irregularities, nausea and constipation; extrapyramidal symptoms; increased and decreased libido; all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis); jaundice and hepatic dysfunction have been reported occasionally; making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension: 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states: 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25 and in boxes containing 10 strips of 10. Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE Roche Products Inc
Manati, Puerto Rico 00701

AMPAC Is Credited For CAP Defeat

The American Medical Political Action Committee has been credited with defeating President Carter's hospital cost containment bill which would have put a cap on hospital costs.

That's according to Common Cause after a study of AMPAC contributions made to members of the House Commerce Committee which recently defeated Carter's bill by a vote of 22-21. The committee then reported a bill which contained no authority for mandatory controls as proposed by Carter.

Common Cause found that the members of the committee who voted against Carter received $88,150 from AMPAC during their congressional races whereas those who supported Carter received only $16,109.

Child Sexual Abuse Exceeds Reported Cases

A recent survey by the University of Washington School of Medicine indicates that the actual incidence of child sexual abuse is far greater than the reported cases.

Responses of physicians to a questionnaire from the medical school indicate that physicians are reluctant to report cases of child sexual abuse encountered in their practice, say Drs. Jennifer James and William M. Womack.

More than half of the doctors responding to the poll said they saw at least one identifiable sexually abused child annually, and some had seen many more cases, say Drs. James and Womack.

Many of the abused children were suffering from severe emotional shock and almost all of them need professional counseling, they declare.

The most common type of sexual abuse is intercourse or molestation by either the natural father or stepfather with a daughter, the survey found. And there also is a relatively high incidence of sexual abuse by another relative, acquaintance, or stranger. No episodes of sexual abuse of boys were reported in the questionnaire.

Two-thirds of the physicians said they sometimes did not report such cases to authorities because reporting would be harmful to the family and that the problem could be handled better privately. The other third was dissatisfied with the manner in which state social service agencies handled such cases.

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CONTENTS

ORIGINAL PAPERS

Amyotrophic Lateral Sclerosis in Cancer **201** Nanda K. Vemireddi, M.D., and Charles A. Crevoiserat, Jr., Kansas City, KS

Fluorides and the Physician: An Update **205** Aaron Trubman, D.D.S., M.P.H., Jackson, MS

SPECIAL ARTICLE

Radiologic Seminar CLXXXVI: Atlantoaxial Rotation Subluxation **208** Douglas E. Clark, M.D., Tupelo, MS

EDITORIAL

The Continuing Controversy of C.P.E. **211** W. Moncure Dabney, M.D., Crystal Springs, MS

THIS MONTH

The President Speaking **210** Identifying Rural Medical Care Needs

Medical Organization **215** Medicare Fees Are Lowest in Mississippi

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$15 Million Offered for Disadvantaged Students

HEW has issued regulations for the administration of a $15 million program designed to attract and aid disadvantaged students pursuing health careers. The regulations are effective immediately, but may be modified after public comments have been received.

Authorized by the Health Professions Educational Assistance Act of 1976 (PL 94-484), the program provides funds to assist schools and other entities to recruit disadvantaged students for training in the health professions, including medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, and public health.

Rodent Rabies Is Not Endemic in U. S.

Rabies is not endemic in rodents, according to the State Board of Health's Bureau of Disease Control. A recent review summarizes the rodent rabies situation in the United States. Although 25,000 rodents are examined for rabies annually by various laboratories, only four or five are found to have rabies. There is no evidence that these few confirmed-rabid rodents play any role in the spread of rabies in its major wildlife hosts, the carnivores. Finally, human rabies has never been traced to a rodent, despite the fact that at least 24,000 persons are bitten by rodents each year.

These data suggest that many of the estimated 4,000 U. S. residents who receive antirabies prophylaxis each year for exposure to rodents are being treated unnecessarily. The American Public Health Association makes the following statement on rabies in rodents: "Rabbits, squirrels, chipmunks, rats and mice are rarely infected and their bites rarely, if ever, call for rabies prophylaxis." An example of the unusual type of rodent exposure that would require rabies prophylaxis would be a bite by a laboratory-confirmed rabid rodent.

Most of the 3,000 cases of animal rabies reported annually in the United States occur in wild or domestic carnivores (skunks, foxes, raccoons, cats, and dogs) or insectivorous bats. Bites by these species may require antirabies treatment as outlined in current treatment recommendation schedules. The most up-to-date and detailed information on the local incidence of animal rabies can be obtained from state health departments or the Center for Disease Control in Atlanta. These agencies also offer valuable advice to the practicing physician on difficult questions concerning rabies prophylaxis.

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Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis

Final classification of the less-than-effective indications requires further investigation

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Br

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents (i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation). Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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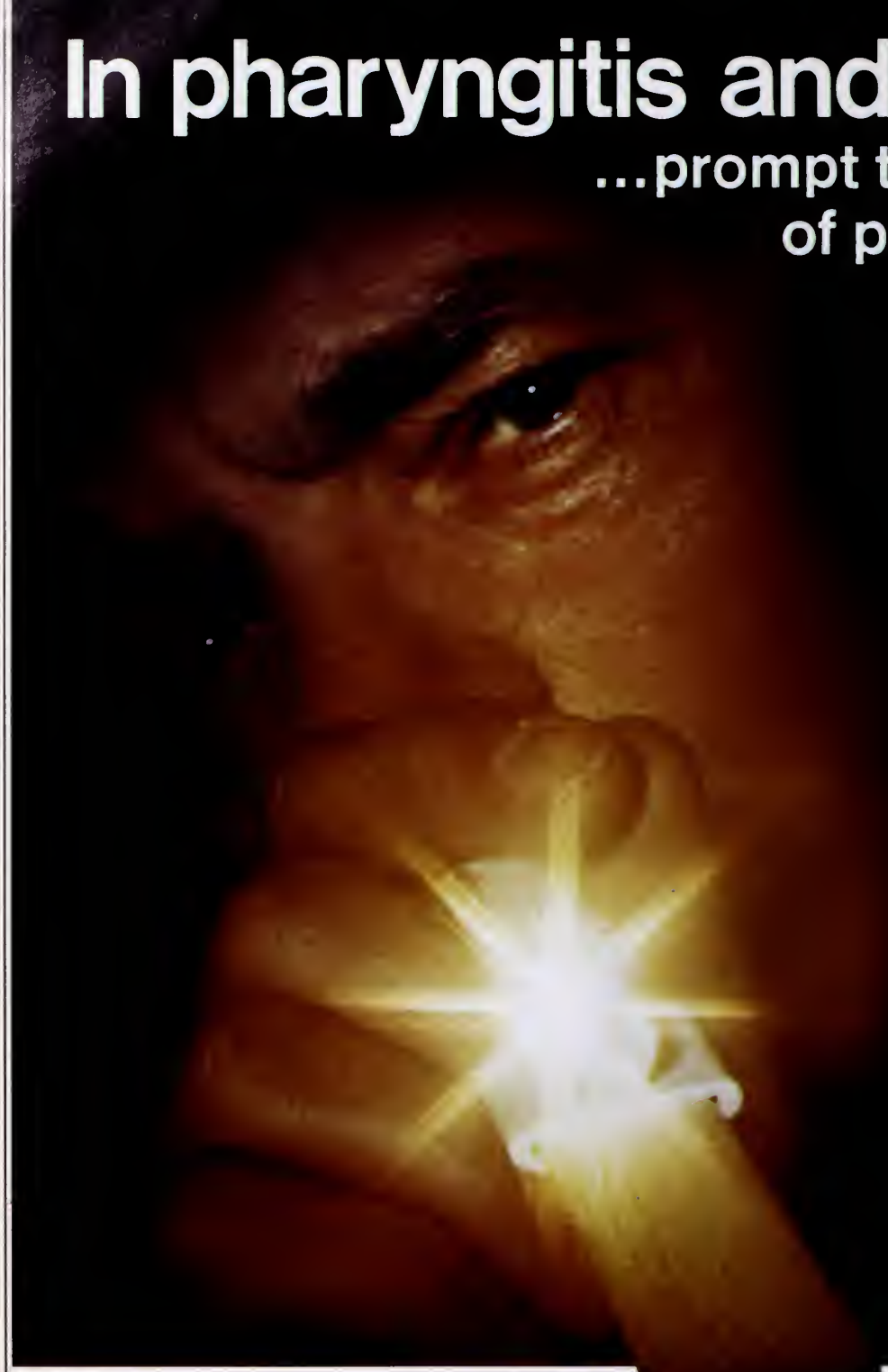
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Free Second Opinions Are Offered

Surgeons in the Cumberland County (Maine) Medical Society have begun offering free second opinions to patients who have had surgery recommended to them.

"Seeking consultation has been a time-honored, traditional part of everyday practice," said Dr. Clement A. Hiebert, president of the Cumberland Medical Society. "And it bothers us that it could become a mechanism by well-intentioned third parties, seeking to reduce the cost of doing business, be it the government or Blue Shield."

Noting that doctors frequently confer on cases without charge to patients, Dr. Hiebert added, "Why can't we extend this to the doctor's office?"

All 84 surgeons who belong to the medical society have agreed to participate in the plan. Under the agreement, the surgeons will notify their patients of the availability of a free consultation by another surgeon.

Study Confirms High Blood Pressure From Obesity

Obesity is a major contributing factor in high blood pressure. Losing excess pounds often will bring down the blood pressure.

In the nationwide Community Hypertension Evaluation Clinic screening of more than one million people, the overweight group had high blood pressure rates 50 to 300 per cent higher than normal weight individuals, says a report in the *Journal of the American Medical Association*.

The report is by Rose Stamler and Dr. Jeremiah Stamler of Northwestern University Medical School, Chicago, and a research group from the Ciba Pharmaceutical Co., Summit, NJ.

Frequency of high blood pressure in overweight persons aged 20 to 39 years was double that of normal weight and triple that of underweight persons, the report says. Among those aged 40 to 64 years, the overweight group has a 50 per cent higher high blood pressure prevalence rate than the normal group and 100 per cent higher than the underweight group.

Since both high blood pressure and obesity are mass phenomena in the United States, even a partially successful effort to persuade the public to reduce might favorably affect millions of people. With safe methods of weight control, such as better longterm nutritional and exercise habits, an important advance might be achieved in the control of high blood pressure, the report concludes.

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NEWSLETTER

November 1978

Dear Doctor:

Based on figures in Profile of Medical Practice 1978 the average U.S. physician in office practice in 1976 was 46 years of age, worked 52.2 hours per week, and averaged $59,544 in income. The new seventh edition of the book also shows that the rate of increase in physician's fees has declined since 1975, to 9.2 per cent as measured by the consumer price index. Information in the book is based in large part on results from the 11th Periodic Survey of Physicians, an AMA study conducted last year.

> HEW announced that the Medicare deductible will go up from $144 to $160 on Jan. 1, 1979. The 11 per cent increase means that Medicare's 27 million beneficiaries will face higher out-of-pocket costs for health care. As health care costs have increased over the last 10 years, Medicare deductible has more than tripled.

Automobile accidents are the leading cause of death for Americans between the ages of 1 and 24, according to the federal government's National Center for Health Statistics. In declining order, the next most prevalent causes of death for people in the United States are homicide, cancer, suicide, and birth defects, reports the NCHS.

Malpractice awards declined by 10 per cent in the state of California last year, according to the State Board of Medical Quality Assurance. On the other hand, the average amount awarded rose 30 per cent. The average amount increased from $41,785 in 1976 to $54,196 in 1977. The total amount was $32.2 million in 1976, rising to $37.4 million in 1977.

Some two million Americans enter hospitals each year with one ailment and wind up with another. The mere fact of being in a hospital exposes them to 'nonsocomial'--- or hospital-related--- infections, which are fatal to as many as 15,000 people per year in the United States, according to an article in the New York Times.

Harvard economist John Kenneth Galbraith, a national health insurance supporter, questioned the idea of controlling only one segment of the inflation-beseiged economy in testimony before the Senate Select Committee on Small Business hearings on the effect of high health care costs on the small business community. Any really relevant policy cannot just single out health costs, said Galbraith.

Sincerely,

Nola Gibson

Nola Gibson
Managing Editor

Utilization Review Lowers Medicaid Stays

A Massachusetts utilization review program, which was the forerunner of professional standards review organizations in the state, has been credited with cutting Medicaid patients' length of stay in hospitals by 5.3 per cent.

Researchers, who published their findings in the *New England Journal of Medicine*, also concluded that the review program had "an educational effect on physicians and hospitals" that may have helped lower the length of hospital stays for non-Medicaid patients. "We conclude that Professional Standards Review Organizations, of which this program was a precursor, can be cost-effective," the researchers said.

They did caution that cost-effectiveness is not an "inevitable outcome" of PSRO's, but added that with "strong management controls" and proper evaluation, PSRO's could save more money than it costs to carry out PSRO review.

In the case of the Massachusetts review program, the researchers estimated that $16.5 million had been saved — or a return of about $4 on every dollar invested in the review.

Lung Diseases Supercourse Is Planned

The fourth annual New Orleans international Supercourse on lung diseases will be Dec. 12-16, 1978, at the Hyatt Regency Hotel in New Orleans, announced Howard A. Buechner, M.D., course chairman.

Supercourse is an intensive postgraduate program that consists of three separate courses running concurrently through the 5-day event; the 15th Annual Pulmonary Function in Health and Disease Course; the 11th Annual Respiratory Care Course; and the 8th Annual Pediatric Pulmonary Course.

The annual program is sponsored by the American Lung Association of Louisiana and its medical section, the American Thoracic Society of Louisiana. Accreditations for the courses are from the American Medical Association in Category 1, the American Academy of Family Physicians for prescribed hours, and the American Association of Critical-Care Nurses.

Tuition for the course is $225. Additional information and complete programs are available from the ATS of Louisiana, 333 St. Charles Ave., Suite 500, New Orleans, LA 70130.

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Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy.* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

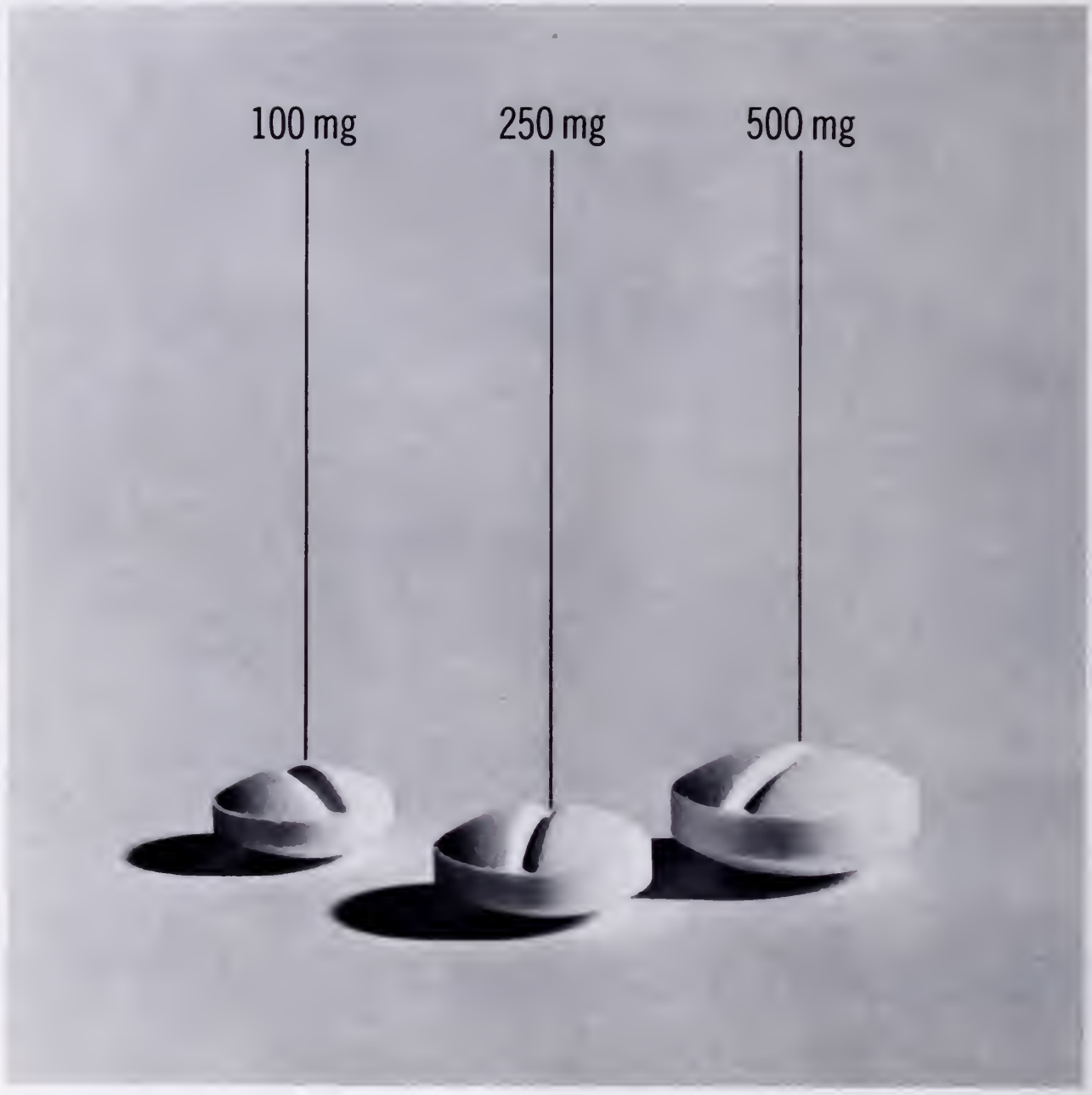
Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

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Internists Will Meet in Nashville

Specialists in internal medicine and related medical fields will take part in a two-day scientific meeting in Nashville, TN, Dec. 1-2.

The Tennessee regional meeting of the American College of Physicians (ACP) is designed to bring physicians up-to-date on late developments in the field of internal medicine. It is one of 40 such sessions held each year throughout the United States and Canada by the 40,000-member medical specialty society.

Physicians who attend the regional meeting are eligible for credit toward the American Medical Association Physician's Recognition Award in Category 1.

In charge of planning for the ACP's Tennessee regional meeting is Blair D. Erb, M.D., F.A.C.P. (ACP Governor for Tennessee) who serves as the medical specialty society's representative in Jackson, TN.

Hospitals Take 40% Of U.S. Health Bill

Hospital spending accounted for $68.4 billion or 40 per cent of the nation's $163 billion health budget during 1977, the Health Care Financing Administration reports.

The annual report of national health expenses noted that hospital spending was one of the fastest growing categories in the health field, up from 34 per cent of all spending in 1965.

Total health expenditures broke down to $737 per resident, 12 per cent higher than spending during 1976. Such expenses continued to ourstrip increases in the economy, since the Gross National Product rose only 10 per cent.

Inpatient days in community hospitals increased by 1 per cent from 1976. Occupancy rates dropped slightly to 74 per cent in 1977 from 74.6 in 1976.

Community hospitals accounted for 82 per cent of hospital care dollars spent in 1977.

Federal programs financed $40 billion of the nation's health costs in 1977. The states paid another $17 billion. State and federal payments for Medicare and Medicaid amounted to 26 per cent of the personal health care bill.

Medicare payments average $1,442 per person. Medicaid payments amounted to $753 per person. Medicare paid 24 per cent of hospital care costs, while Medicaid paid 9 per cent.

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DATELINE

Family Practitioners Are Increasing

Chicago, IL -- Much progress has been made in increasing the number of family practice physicians in the past 11 years, but there still remains much more to be done, says a report in JAMA. Since the AMA's Ad Hoc Committee of Education for Family Practice presented its program in 1966, the number of approved family practice residency programs had grown to 325 by mid-1977. Number of residents enrolled increased to 5,421 and the number of first-year residents increased to 2,043.

Dependent Children Enrollment Decreases

Washington, DC -- The number of persons on the rolls of the nation's largest welfare program, Aid to Families with Dependent Children, decreased in 1977 for the second straight year, although the number of families increased slightly, according to the Social Security Administration. The average monthly caseload of AFDC recipients was 11,018,158 in 1977, down 2.3 per cent from 11,279,861 per month in 1976. The average AFDC family now has three persons-- mother and two children.

Physicians Should Be on Federal Boards

Washington, DC -- A proposal to regulate composition of boards and committees of carriers, intermediaries, and fiscal agents participating in Medicare and Medicaid, should be withdrawn the AMA told HEW. The association said the proposal "is based on the false notion that being a member of the medical profession one would be motivated by self-interest to oppose cost effective health care." HEW was concerned that the influence of persons with a financial interest in health care delivery "may" compromise carriers and agents.

Physicians Protected at Sporting Events

Sacramento, CA -- A 1978 California statute provides that "no physician and surgeon who in good faith and without compensation renders voluntary emergency medical assistance to a participant in a school athletic event or contest at the site thereof, or during transportation to a health care facility, for an injury suffered in the course of event or contest, shall be liable for any civil damages as a result of any acts or omissions by the physician and surgeon in rendering the emergency medical care."

FDA Audits Its Own Laboratories

Washington, DC -- FDA laboratories that do nonclinical toxicology testing are to be inspected over the next several months using the same Good Laboratory Practices (GLPs) that the agency applies to industry. In addition to checking the conditions of FDA laboratories, the inspections are intended to show, according to Commissioner Donald Kennedy, that there are "no double standards", one for government and one for industry.



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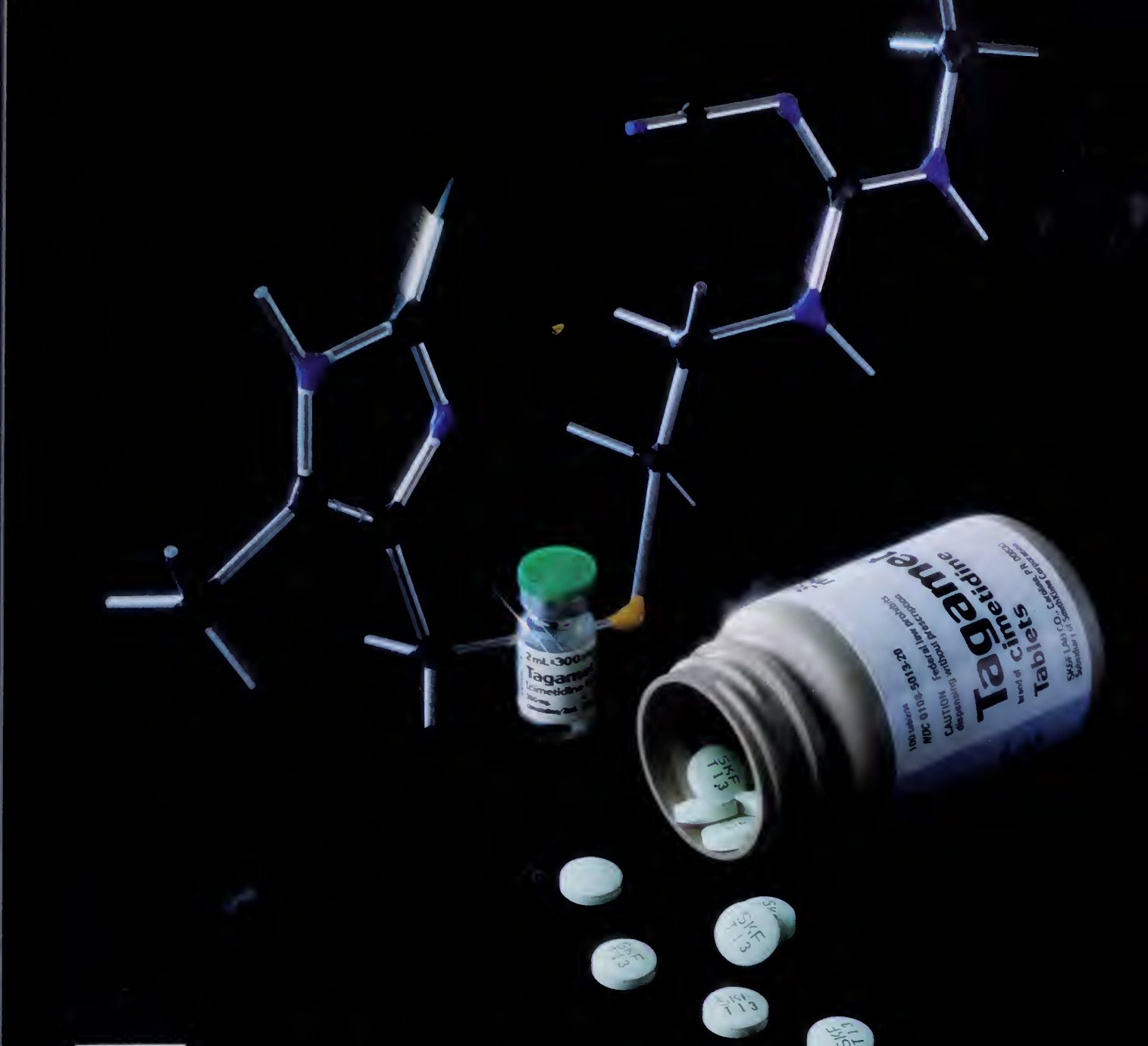
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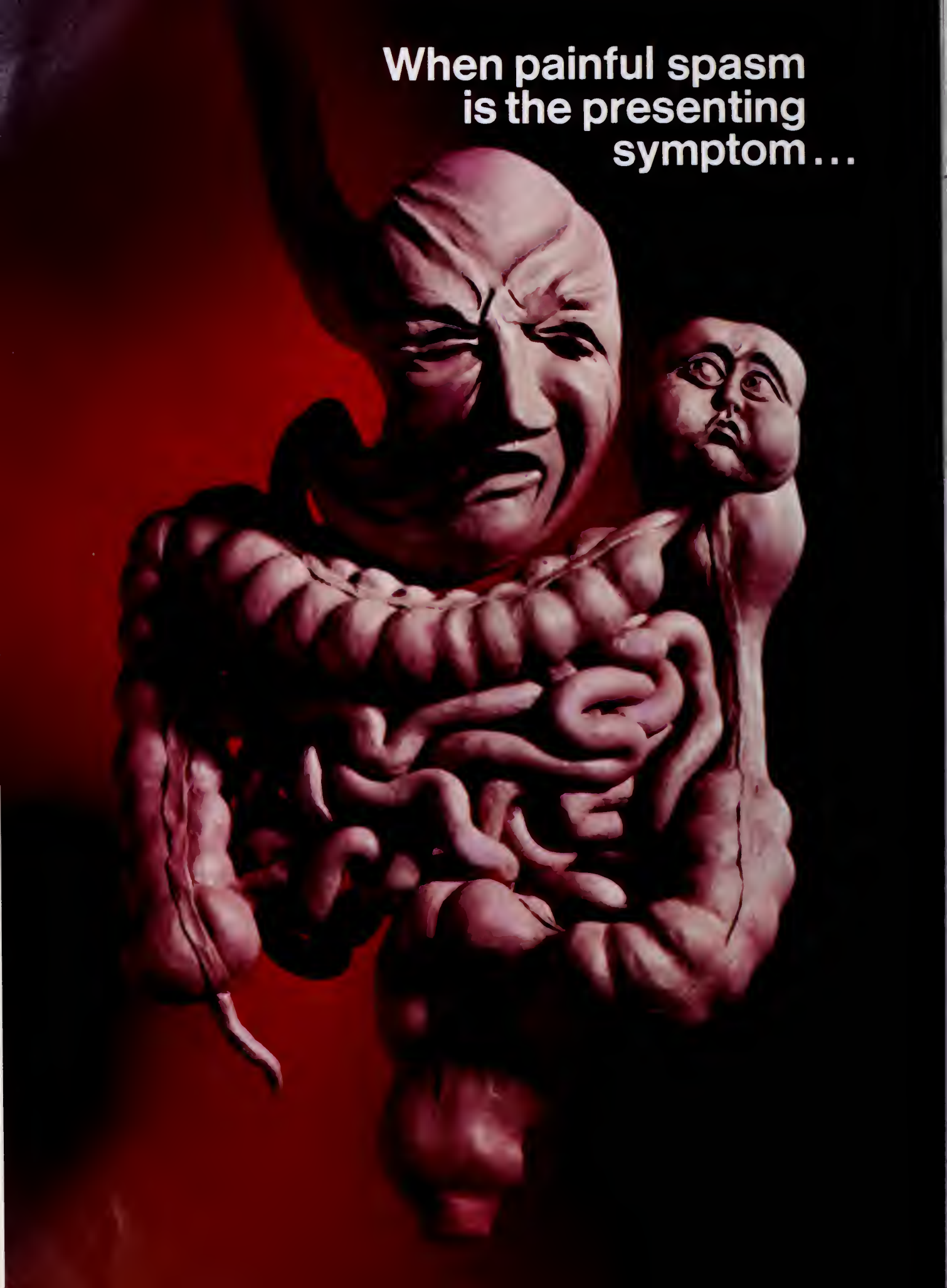
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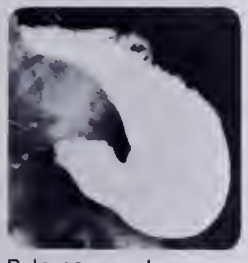
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*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS

For use in the treatment of infant colic (syrup)

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus; intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with autonomic neuropathy, hepatic or renal disease, ulcerative colitis—Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon, hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension, hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia, urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION Dosage must be adjusted to individual patient's needs.
Usual Dosage Bentyl 10 mg. capsule and syrup *Adults* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children* 1 capsule or teaspoonful syrup three or four times daily. *Infants* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg. *Adults* 1 tablet three or four times daily. Bentyl Injection *Adults* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.
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Dental Insurance Coverage Grows

Dental insurance is the fastest growing form of health protection in the United States, reports the Health Insurance Institute.

Since 1970 the number of Americans with some form of dental insurance has gone up from 13 million to 44 million — an increase of 238 per cent.

Providing most of this protection are insurance companies which in 1976 insured 26.7 million persons under dental plans mostly through plans on groups of employees.

Along with the growth in the number of persons with protection against dental expenses has come an increase in benefits for dental care. For example, insurance company payments for dental expenses totaled $951 million in 1976, up from $140 million in 1970 — an increase of almost 600 per cent.

Pediatricians Announce Health Promotion

The American Academy of Pediatrics, representing more than 15,000 American pediatricians, has announced a national program to "cause consciousness-raising across the American community concerning the total health and welfare of all its children."

Dr. Saul J. Robinson, president of the AAP, said the effort is called SPEAK UP FOR CHILDREN! The program will begin in January 1979, designated by the United Nations as the International Year of the Child.

"Pediatricians throughout the country believe it is time that all of us recognize the special needs of infants, children and adolescents," Dr. Robinson said. "We want the country to stop wasting its most valuable natural resource — children."

The national program will seek to make use of pediatricians as volunteer spokespersons to educate the public about child health issues. While the program hopes to increase awareness about the full range of issues affecting children, Dr. Robinson said, it focuses most heavily on the subject areas of accident prevention, health education, immunization, and nutrition. Dr. Robinson said pediatricians would spread the program's message in their offices and communities, and through use of the local print and broadcast media. In addition, he said, state chapters of the academy would support legislation or action programs in the four areas of emphasis.

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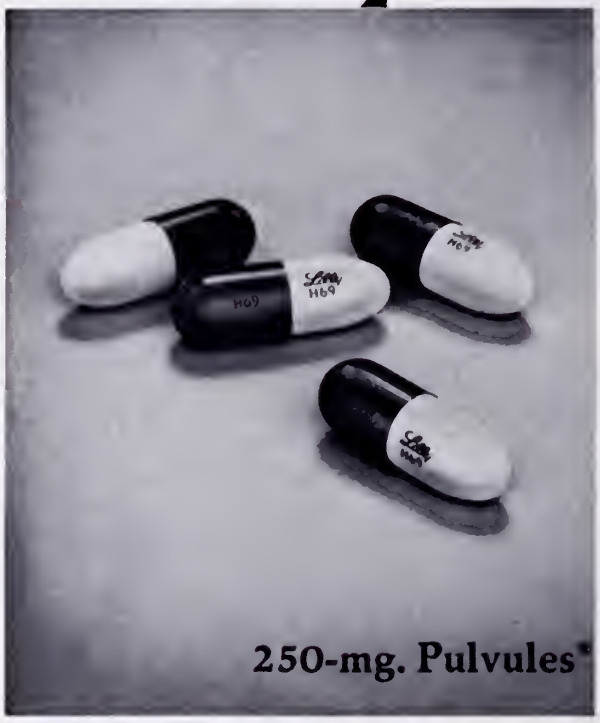
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November 1978, Vol. XIX, No. 11

ORIGINAL PAPERS

Amyotrophic Lateral Sclerosis in Cancer

NANDA KUMAR VEMIREDDI, M.D., and
CHARLES A. CREVOISERAT, JR.
Kansas City, Kansas

ABOUT A CENTURY ago Charcot described amyotrophic lateral sclerosis (A.L.S.), which is characterized by a progressive, chronic, degenerative and fatal motor paralysis occurring in adults. The clinical features are attributable to degeneration of the motor nuclei at the spinal or brain stem levels, or at both levels, usually with involvement of the Betz cells of the cortex and demyelination of cortico-bulbar and cortico-spinal (pyramidal) tracts.

When the clinical involvement is characterized by anterior horn cell involvement alone, the state is called progressive muscular atrophy (P.M.A.).[1] The disease is known to occur more often among males (farmers and heavy laborers),[2] with life expectancy of about 3-5 years from the time of diagnosis. Occasionally in some forms of A.L.S., they may live as long as 10-20 years without complications. This degenerative disease process usually starts between the ages of 40-70 years.[3]

There is no concrete evidence that the disease has occurred in clusters except among the Chamorro people of the Mariana Islands in the Pacific and the Kii Peninsula of Japan.[4]

Yase[5] noted increased deposits of calcium in the central nervous system of A.L.S. patients, and theorized that this might be a necessary condition for the development of the disease. Currier et al[2] noted no connection between the amount of mercury or lead in the patients' tissue and their A.L.S. in spite of patients' exposure to these metals in their jobs. Kurland et al[1] reported that the average annual age adjusted death rates for A.L.S., in 1959-1961 among the 50 states, ranged from 0.3 to 1.0 per 100,000 population. Because the rates for most states were between 0.4 and 0.7, they concluded the A.L.S. rates must be considered homogenous.

From the Department of Rehabilitation Medicine, University of Kansas Medical Center, Kansas City (Dr. Vemireddi) and the Bureau of Registration and Health Statistics, Topeka, KS (Mr. Crevoiserat, research analyst).

Amyotrophic lateral sclerosis (A.L.S.) is a progressive, chronic, degenerative and fatal motor disease. The authors conducted a statistical analysis of deaths occurring from motor neuron disease in the state of Kansas during 1950-76. They present their findings as to the sex, age, occupation, familial distribution and geographic distribution of the victims of this disease.

The recent study that the neurologic disease "KURU," found among the natives of New Guinea who practiced Cannibalism, and Cretzfeldt-Jacob in man are due to "Slow Viruses: — Viruses with long incubation periods" — has shed new light on A.L.S., which is now thought possibly due to a slow virus.[6] Today, the exact cause of A.L.S. is still unknown and remains a mystery.

Methods of Data Collection

The state of Kansas Department of Health and Environment routinely compiles information, for statistical purposes, on all deaths registered with the state. Using this data, information on persons who died of motor neuron disease and muscular atrophy (M.N.D.M.A.) in Kansas for the years 1950-1976 was selected for analysis. M.N.D.M.A. deaths were then classified as amyotrophic lateral sclerosis and progressive muscular atrophy. In addition, death certificates of persons who died of M.N.D.M.A. were scrutinized to find out their occupations.

To explore the hereditary aspects of the disease, we selected the 55 Kansans who were victims of A.L.S. during 1974-1976 and a questionnaire was sent to their close blood relatives requesting information about such disease activity in other members of the family.

Results

In the United States M.N.D.M.A. deaths during 1950-1973 show an increasing trend. In spite of a decline in deaths due to progressive muscular atrophy by 74.1 per cent (see Table 1), M.N.D.M.A. deaths increased from 1,006 in 1950 to a high of 1,596 in 1968 — an increase of 58.6 per cent in 19 years. This increase is due to the fact that A.L.S. deaths rose by 114 per cent — from 667 deaths in 1950 to a high of 1,410 in 1968. This is probably due to a change in diagnostic criteria.

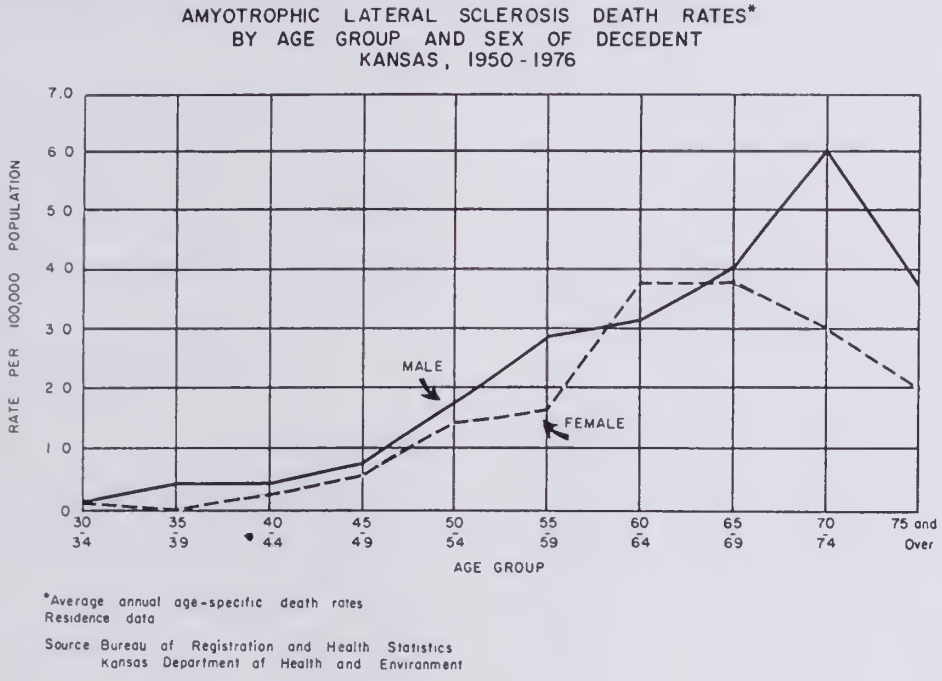
A.L.S. mortality rates during 1950-1968 increased by 1 death per million population every 7-8 years. The rate increased from 4.2 per million in 1950, to 5 in 1951, to 6 in 1959 and to 7 in 1966. It is expected that the rate in 1973 will be about 8 per million population if the present trend prevails. During 1950-1976, Kansas registered 457 A.L.S. deaths among its residents. In 1967, there were 26 deaths, a rate of 13 per million population (a record high number of A.L.S. deaths); a similar number of deaths occurred in 1962 also. A low of 7 deaths was reached in 1957, a rate of 3.3 A.L.S. deaths and rates show a cyclic pattern, reaching a maximum every fourth year. The succeeding peak is always lower than the previous high.

TABLE I

NUMBER OF DEATHS AND RATES DUE TO MOTOR NEURON DISEASE AND MUSCULAR ATROPHY, AMYOTROPHIC LATERAL SCLEROSIS, AND PROGRESSIVE MUSCULAR ATROPHY, UNITED STATES, 1950-1973, KANSAS 1950-1976

	Number of Deaths						*Rate per 100,000 population*					
	UNITED STATES			KANSAS			UNITED STATES			KANSAS		
Year	M.N.D.M.A.	A.L.S.	P.M.A.	M.N.D.M.A.	A.L.S.	P.M.A.	M.N.D.M.A.	A.L.S.	P.M.A.	M.N.D.M.A.	A.L.S.	P.M.A.
1976	—	—	—	27	24	2	—	—	—	1.2	1.0	0.1
1975	—	—	—	23	19	4	—	—	—	1.0	0.8	0.2
1974	—	—	—	16	12	3	—	—	—	0.7	0.5	0.1
1973	1,935	1,736	139	28	23	4	0.9	0.8	0.1	1.2	1.0	0.2
1972	1,882	1,716	118	26	24	2	0.9	0.8	0.1	1.1	1.1	0.1
1971	1,793	1,593	143	27	23	3	0.9	0.8	0.1	1.2	1.0	0.1
1970	1,752	1,546	166	29	23	6	0.9	0.8	0.1	1.3	1.0	0.3
1969	1,640	1,441	164	21	19	1	0.8	0.7	0.1	0.9	0.8	0.0
1968	1,596	1,410	148	25	24	—	0.8	0.7	0.1	1.1	1.1	—
1967	1,589	1,355	109	28	26	2	0.8	0.7	0.1	1.3	1.2	—
1966	1,589	1,349	115	20	15	4	0.8	0.7	0.1	0.9	0.7	0.2
1965	1,438	1,225	104	28	24	1	0.7	0.6	0.1	1.3	1.1	0.0
1964	1,370	1,147	124	20	17	1	0.7	0.6	0.1	0.9	0.8	0.0
1963	1,409	1,191	142	17	16	1	0.7	0.6	0.1	0.8	0.7	0.0
1962	1,427	1,164	153	28	26	1	0.8	0.6	0.1	1.3	1.2	0.0
1961	1,277	1,068	154	20	16	3	0.7	0.6	0.1	0.9	0.7	0.1
1960	1,273	1,066	158	12	12	—	0.7	0.6	0.1	0.6	0.6	—
1959	1,230	1,011	169	13	11	2	0.7	0.6	0.1	0.6	0.5	0.1
1958	1,174	937	195	13	12	1	0.7	0.5	0.1	0.6	0.6	0.0
1957	1,089	854	197	17	14	3	0.6	0.5	0.1	0.8	0.7	0.1
1956	1,095	849	203	12	7	3	0.7	0.5	0.1	0.6	0.3	0.1
1955	988	748	211	14	10	3	0.6	0.5	0.1	0.7	0.5	0.1
1954	1,032	738	260	20	11	8	0.6	0.5	0.2	1.0	0.6	0.4
1953	1,001	734	246	14	9	4	0.6	0.5	0.2	0.7	0.5	0.2
1952	1,062	728	304	16	14	2	0.7	0.5	0.2	0.8	0.7	0.1
1951	1,103	770	296	24	14	9	0.7	0.5	0.2	1.2	0.7	0.5
1950	1,006	667	317	16	12	4	0.7	0.4	0.2	0.8	0.6	0.2

Sources: Vital Statistics of the United States, DHEW, Vol. III, 1950, Vol. II, 1951-1959, Vol. II Part A, 1960-1973. Vital Statistics of Kansas (unpublished). Bureau of Registration and Health Statistics, Kansas Department of Health and Environment.



Sex

Previous literature reports that A.L.S. occurs among males more often than among females, with a ratio of anywhere from 2 to 4 in favor of males. Mackay[3] reports a ratio of 2.5 : 1 in favor of males, based on 70 cases. The U. S. mortality data indicates a smaller ratio than that reported by several authors. The ratio is smaller than 2, and in recent years appears to be closer to 1.5 : 1 in favor of males (see Graph 1).

In Kansas, there are more A.L.S. deaths among males than among females (55 per cent (252) among the males and 45 per cent (205) among females) giving a sex of 1.4 in favor of males (see Table II).

Age

During the study period 1950-1976, 84 per cent of the deaths occurred among persons between 40-75 years of age. All the A.L.S. death victims were persons 30 years of age or older. About 66 per cent of deaths occurred among persons 60 years and above and about 96 per cent of the deaths occurred among persons 40 and above. The average age at death for males was 63 years and the female was 64 years. Since 96 per cent of the deaths occurred among persons over 40 years of age, the results of this study confirm the previously reported findings that the disease occurs predominantly among persons 40 and older (see Table II).

TABLE II

AMYOTROPHIC LATERAL SCLEROSIS DEATHS BY AGE GROUP AND SEX OF THE DECEDENT
KANSAS, 1950-1976

Age Group	*Total*	*Male*	*Female*
All ages	457	252	205
Under 30 years	—	—	—
30-34 years	3	2	1
35-39 years	7	7	—
40-44 years	11	7	4
45-49 years	20	11	9
50-54 years	46	25	21
55-59 years	61	38	23
60-64 years	85	37	48
65-69 years	83	40	43
70-74 years	75	47	28
75 + years	66	38	28

Source: Bureau of Registration and Health Statistics, Kansas Department of Health and Environment.

Occupations

According to the 1970 census, Kansas has about 2,200,000 persons, about 15 per cent of whom are engaged in farm related work. A.L.S. deaths (total 55) among farmers during 1974-1976 period accounted for 10.9 per cent. An additional 29.1 per cent of A.L.S. deaths occurred among housewives. The working class, which includes laborers,

craftsmen, foremen and service workers, accounts for 41.8 per cent of the total A.L.S. deaths. The remaining 18.2 per cent occurred among the other occupations — professionals, clerical and the like.

Familial Distribution

Questionnaires were sent to close blood relatives of 55 Kansans who died of A.L.S. during 1974-1976 and 41 responses were received. None of the families reported a second case of A.L.S. among them.

Geographic Distribution

During the 26-year period, 1950-1976, there were no A.L.S. deaths in 18 counties, 1-4 deaths in each of 58 counties and 5-8 A.L.S. deaths in each of the 18 counties. The remaining 11 counties each had 10 or more deaths. Sedgwick County had 51 deaths during 1950-1976, the highest number of A.L.S. deaths registered by a county. The next highest number of A.L.S. deaths was Shawnee with 29. Incidentally, these two counties are the most populated counties in the state which could explain the larger numbers. The figures do not show any predilection for higher incidence in any particular county.

Summary

This study was based on data derived from deaths due to A.L.S. registered in Kansas during the years 1950-1971. The results of this study confirm the previously reported findings regarding A.L.S. The disease is seen primarily among persons 40 years of age and above. There were more deaths among males; a sex ratio of 1.4 : 1 in favor of males, and more deaths among laborers and craftsmen followed by housewives. The life expectancy from the date of onset is about 2-4 years. There is no geographic predilection in A.L.S. death rates. Further, the mortality data for Kansas show neither an increase in the incidence of A.L.S. nor a shift in the diagnostic custom. ★★★

Veterans Administration Medical Center
4801 Linwood Boulevard (64128)
(Dr. Vemireddi — Kansas City)

Acknowledgement

The authors are grateful to Darrel L. Ekland, chief, Research and Analysis Section of Bureau of Registration and Health Statistics, Topeka, KS, for material help received.

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The school board was inspecting the elementary classrooms one afternoon, and the principal asked the youngsters if they knew who the men were. Total silence.

"These are the trustees," he explained.

"Now, do you know what they do?"

"Yessir, I do," volunteered one little boy. "They're the ones who cut the grass at the governor's mansion."

Fluorides and the Physician: An Update

AARON TRUBMAN, D.D.S., M.P.H.
Jackson, Mississippi

DENTAL CARIES is the most prevalent disease in highly developed societies, thus means to reduce its occurrence should be the concern of not only dentists but physicians as well. The physician should be acquainted with and encourage effective methods to reduce this health problem.

Fluorides are the most effective, safe and economical means available to reduce dental caries. Essentially, fluorides increase the resistance of tooth enamel to the caries process. In addition, they also promote remineralization which can result in arresting the incipient carious lesion.

The anticaries effect of fluorides, dietary and topical, has been generally known and utilized for more than 30 years. During this period various fluoride compounds and methods of topical application have proven effective. More recently, great advances in self-administration of topical fluorides have occurred.

Water Fluoridation

The scientific evidence is overwhelming that consumption of drinking water containing adequate fluoride is the most effective and economical method of fluoride administration. (The Mississippi State Board of Health recommends 0.8-1.2 parts per million (ppm) fluoride.) The maximum benefit of fluoride is obtained when an individual drinks fluoridated water from birth to approximately 12 years of age. During that period the crowns of the permanent teeth are undergoing calcification. Fluoridated water also exerts a topical effect on the teeth. Not only do children benefit from drinking fluoridated water, but the benefit continues into adulthood.[1]

The physician concerned with the overall health of his patients and community should encourage communities and other groups with publicly-owned water supplies to adjust the level of fluoride to the recommended level. Lack of support for this public health measure is too often taken by community leaders and residents as either opposition to fluoridation or minimizing the need to reduce dental caries. Valid, scientific information on all aspects of fluoridation can be obtained from the American Dental Association, American Medical Association and the Mississippi State Board of Health.

From the Division of Public Health Dentistry, Mississippi State Board of Health, Jackson, MS.

Dental caries is the most prevalent disease in highly developed societies like the U. S., points out the author, a public health dentist. Fluorides have been proven to be effective against caries. He presents an update on fluorides and various means of administering them: through the water supply, individual supplements, and topical fluorides. He urges physicians to become acquainted with and to encourage effective methods to reduce the dental caries health problem.

There is overwhelming evidence that a properly operated fluoridation program can reduce dental caries by as much as 60-65 per cent. The cost of fluoridation equipment is small and annual operating cost in Mississippi would be a maximum of approximately 15 cents per person. The operation of a fluoridation program is a simple procedure, not requiring additional staff for water systems.

Although not applicable in Mississippi, since schools derive their water from outside sources or are planning to do so soon, school water fluoridation is another method of providing a beneficial level of fluoride in the drinking water. This is achieved by fluoridating the school's own water supply. School fluoridation should be considered only where the children's home water sources have very little or no fluoride. Since children do not generally enter school until 6 years of age and are in school only part-time, the fluoride level is maintained at approximately 5.0 parts per million. A dental caries reduction of 40 per cent has been demonstrated with a school fluoridation program.[2]

Individual Fluoride Supplements

The physician prescribing fluoride supplements must take into consideration the age of the child and the fluoride content of his or her water supply. Where the drinking water contains 0.7 ppm fluoride or above, individual fluoride supplements should not be prescribed. As in water fluoridation, the maximum beneficial effect will be achieved during the

first 12 years. Information on fluoride content of publicly-owned water supplies is available from the Mississippi State Board of Health. For children on private water supplies, the fluoride content of the water must be determined individually. The Mississippi State Board of Health will analyze fluoride content of these supplies upon request.

Fluoride supplements instituted in infancy and faithfully administered could produce essentially the same anticaries effect as water fluoridation but at a greater cost and without the topical benefit of drinking fluoridated water. However, most children do not see a dentist until 2-3 years of age, but will be seen by a physician. Thus the physician has the unique opportunity to start the child on a fluoride supplement regime at the optimal time in life.

In prescribing dietary fluoride supplements, the following amounts are recommended:[3] a total of 0.25 mg. of fluoride daily for children under 2 years of age; a total of 0.5 mg. of fluoride daily between ages 2 and 3; a total of 1.0 mg. of fluoride daily for those over 3 years.

In prescribing dietary fluoride supplements, no more than 264 mg. of sodium fluoride should be dispensed at one time.[3] This will prevent accidental overdosage that can produce acute toxicity in children. As a further safety measure, the fluoride preparation should be kept out of reach of children.

Prescribing fluoride to expectant mothers has not been conclusively demonstrated to be beneficial to offspring. The Food and Drug Administration[4] therefore forbids selling such preparations stating claims of anticaries benefit to offspring. However, there is no evidence that it is hazardous to the expectant mother or child.

Topical Fluorides

Topical fluoride applications have demonstrated an overall reduction in dental caries of 20-40 per cent, depending upon agent, method and frequency of application. The protective benefit of topical fluoride applications is especially recommended for those living in areas with inadequate fluoride in the drinking water. Topical fluoride can also be beneficial to those living in adequate fluoride areas who have a high susceptibility to dental caries. The two methods of applying topical fluorides are professionally and self-administered. Various fluoride agents, methods and frequency of application are utilized.

Professional applications (by dentists, dental hygienists and other dental staff under supervision) are usually done during the semi-annual or annual visit. However, more frequent applications may be indicated for patients with high caries activity. There is inconclusive evidence that dental prophylaxis pastes containing fluorides produce an anticaries effect.

Dentifrices containing fluoride are a method of self-administered topical fluoride and some have been found to be effective in reducing dental caries. The American Dental Association's Council on Dental Therapeutics evaluates studies on such dentifrices and publishes reports on their effectiveness. These reports are found in their publication, *Accepted Dental Therapeutics*, and are revised between editions in issues of the *Journal of the American Dental Association*.

Self-administration of various fluoride gels and solutions has produced significant anticaries results. Administration of these agents can be accomplished on an individual or group basis. Self-administered fluoride gels or solutions are recommended on a daily or weekly basis, depending upon the agent used. One simple, inexpensive self-administered procedure is the use of weekly sodium fluoride mouthrinse. The Mississippi State Board of Health has conducted a school fluoride mouthrinse program for the past 3 years, with more than 100,000 elementary school children participating. This program is available at no charge to schools or children.

Summary

Oral health is an integral part of the health of a person, and thus is a legitimate concern of the physician.

Fluorides, by various methods of administration and agents, have proven to be effective in reducing the most prevalent disease in our population, dental caries.

The physician should be acquainted with fluoride and its relation to dental health and advocate or prescribe where indicated:

—water fluoridation.

—individual fluoride supplements for young children.

—topical fluoride applications. ★★★

P.O. Box 1700 (39205)

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Riverside.

Mississippi's Unique Psychiatric Hospital.

Riverside Hospital is unique in Mississippi.

As a privately owned 56-bed short term care facility for treating patients with psychiatric illness or emotional problems, it is the only hospital of its kind in the state.

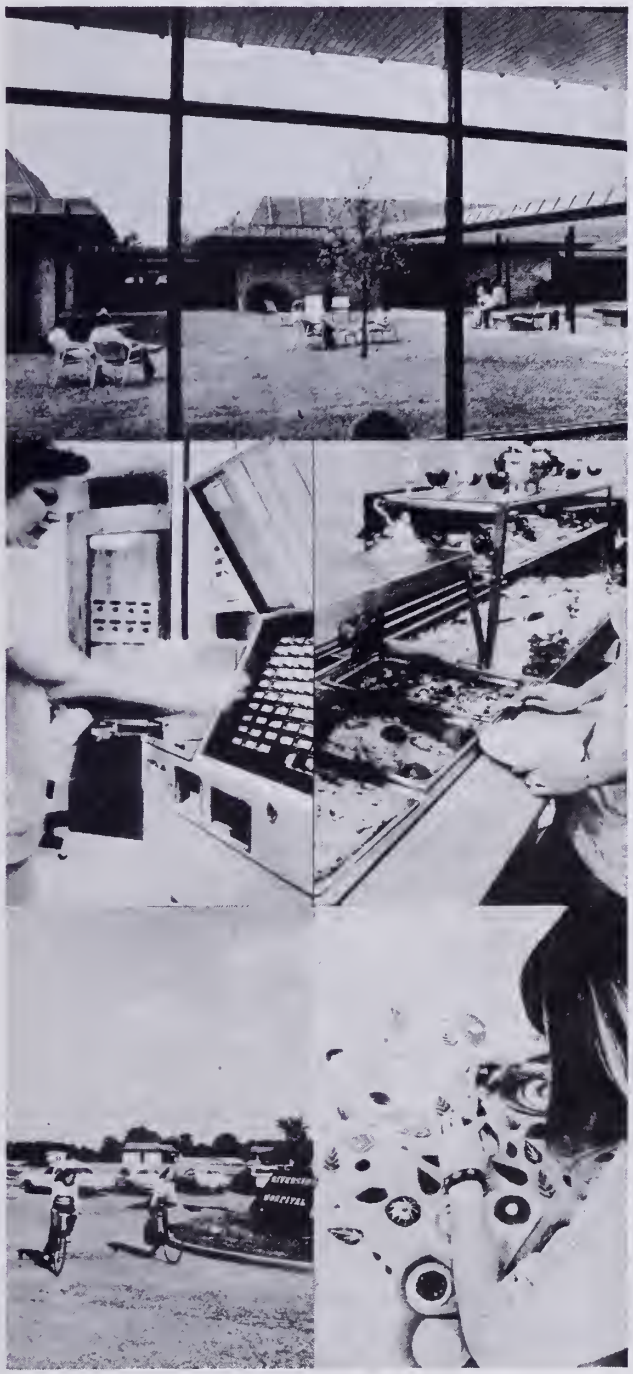
Architecturally designed to create an attractive open environment, Riverside's "non-institutional" atmosphere helps prepare the patient for specific therapy, healthy entertainment and physical recreation.

The clinical program incorporates a wide range of modern psychiatric ideas. Emphasis is placed on interpersonal relationships, small group functions, and professional individualized care.

The Medical Staff includes a large number of physicians in private practice in the Jackson area. All are qualified and limit their practice to psychiatry.

Riverside is licensed by the Mississippi Commission on Hospital Care, and fully accredited by the Joint Commission on Accreditation of Hospitals.

For additional information contact: John R. Reedy, Executive Director.



Riverside Hospital

P.O. Box 4297, Jackson, MS 39216
Telephone: (601) 939-9030

Radiologic Seminar CLXXXVI: Atlantoaxial Rotation Subluxation

DOUGLAS E. CLARK, M.D.
Tupelo, Mississippi

ROTATIONAL subluxation of the atlas upon the axis is a relatively uncommon abnormality of the upper cervical spine. It has been associated with upper respiratory tract infection, minor trauma, and major trauma. Rotational deformities of the atlantoaxial joint are usually short lived and easily correctable. Rarely, they are persistent, causing torticollis which is resistant to treatment. The deformity is said to be somewhat more common in children than in adults and occurs when the atlas locks in rotation on the axis. The mechanism of the locking is poorly understood, but may be due to capsular interposition, irregularity of the articulating process due to occult fractures, or to complete dislocation. The diagnosis of rotatory atlantoaxial deformity is based on an awareness of the condition and a combination of clinical and radiographic findings. Generally, the subluxations are minor injuries and may reduce spontaneously or require traction. In cases where the diagnosis is overlooked the lesion may become fixed and require more extensive treatment, including surgical fusion.

In a recent case seen at North Mississippi Medical Center, a patient presented following a motor vehicle accident in which the patient was the driver of the vehicle. The patient, apparently anticipating a collision, turned her head to the right side to look into the back seat where her children were riding. At the moment of impact stresses of flexion and extension were applied to the cervical spine with the head rotated to the right. The patient presented to the hospital with pain in the upper cervical region, most severe on the left side. The head was rotated to the right and tilted slightly to the left.

Initial radiographs showed no fracture of the cervical spine. Due to the inability to definitely visualize the odontoid process and lateral masses of C1, additional radiographs and tomograms were obtained. The findings were thought to be typical for rotary subluxation of C1 upon C2. The radiographs showed that the lower cervical spine was rotated to the left in increasing amounts from C7 and C2. This is demonstrated by the position of the spines of the cervical vertebrae. These lie progressively further to the right of the midline indicating rotation of the lower cervical spine to the left. Despite the rotation of the lower cervical spine to the left, the patient's head is rotated to the right as indicated by the position of the patient's chin. Under normal circumstances, if the patient's head is rotated, the patient's



Figure 1. The lower cervical spine is rotated to the left as indicated by the spine of C2 (arrowhead) lying to the right of the anticipated midline. The patient's head is rotated to the right as indicated by the position of the patient's chin.

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, North Mississippi Medical Center, Tupelo, MS.

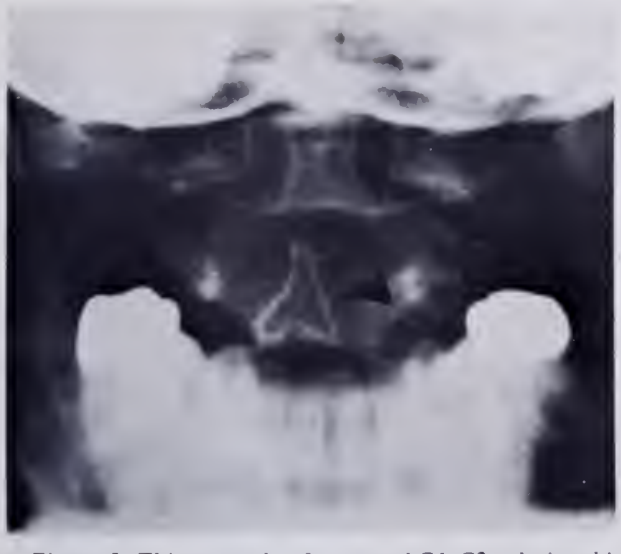


Figure 2. This example of a normal C1-C2 relationship shows the spine of C2 to lie in the midline.

chin and the spinous process of C2 should be on the opposite sides of the midline indicating the head and the cervical spine are rotating as a unit. The findings of the spinous process of C2 and the patient's chin lying on the same side of the midline are said to be pathognomonic for rotational subluxation if they are irreversible (see Figure 1). The patient can generally increase the deformity but cannot correct deformity. Tomograms of the upper cervical spine showed asymmetry of the lateral masses of C1. In addition the lateral masses were in focus on tomography at different levels. Some angulation of the plane of C1 to the plane of C2 was also noted. The findings on the cervical radiographs returned to normal with the patient in traction.

In summary, careful attention to the upper cervical spine is indicated in patients with cervical spine injuries and persistent torticollis. The typical positioning of the head should arouse clinical suspicion. Careful radiographic examination of the atlantoaxial region including tomography is needed to demonstrate rotational deformity and to exclude subtle fractures. ★★★

835 S. Gloster (38801)

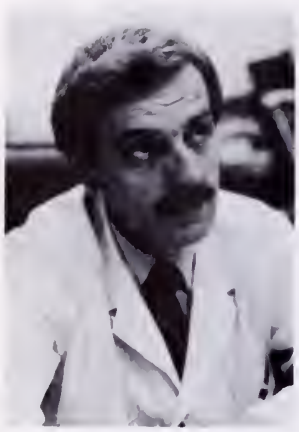


Figure 3. The patient could not rotate the head toward the midline further than demonstrated. She corrects for the slight tilt of the head to the left by tilting the shoulders to the right.

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AMA Interim Meeting
Palmer House, Chicago
Dec. 3-6, 1978



The President Speaking

Identifying Rural Medical Care Needs

CARL G. EVERS, M.D.
Jackson, Mississippi

GOVERNOR FINCH recently named a physician committee to plan a rural medical care conference to be conducted at the Downtown Holiday Inn in Jackson on Nov. 30. The conference will be titled "The Governor's Rural Health Conference II." I hope as many of you as possible will attend this important meeting.

The planning committee, which is composed for the most part of family physicians practicing in non-urban areas of our state, has an imposing task. There are no ready-made solutions to our state's rural medical care problems. Reasonable men even differ over what are the real problems.

In a recent MSMA poll on what "problems" were seen by the membership in their respective practices, physicians in some areas of the state identified a physician shortage. Others saw transportation and poor reimbursement schedules under Medicaid and Medicare as problems. The latter is borne out by a recent nationwide study which showed that Mississippi ranks last in Medicare reimbursement for physicians' services. So to define the problem, much less the solutions, will be an imposing task for "The Governor's Rural Health Conference II."

At this time government through such programs as health planning, the National Health Service Corps, training of physician extenders, and one could go on, offers many "solutions" to rural medical care problems. There is some question as to just how effective these solutions have been. The General Accounting Office, for example, recently found that only 42 physicians out of a total of about 800 who served in the corps remained in the physician shortage area they were assigned to.

There is no question, however, that health planning and the other alphabet soup of government activity in medical care is where the action is and with us or without us decisions are being made.

We must become more active in these matters perhaps remembering and reinforcing Section 10 of our own "Principles of Medical Ethics" namely that "the honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and community."

I submit that we are our patients' (the public's) most knowledgeable and best advocates on medical care matters. Let's not hide our light. Let's attend and speak out at the "Governor's Rural Health Conference II." ★★★

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XIX, Number 11

NOVEMBER 1978

The Continuing Controversy of C.P.E.

Only a few decades ago an M.D. degree and state licensure entitled a physician to practice medicine and surgery for a lifetime, with virtually no restrictions.

Advances in technology and wider knowledge soon made it apparent that specialization was needed. As specialization became more widespread, certification by the respective boards of their members was the next logical step to denote adequate training in and comprehension of the subject. However, this certification essentially conferred lifetime unrestricted endorsement.

It was in the early fifties that the American Academy of General Practice faced the necessity for continued medical education and demanded that its members show objective evidence of C.P.E. for continued membership.

In the September issue of the JOURNAL MSMA our President presented some thoughtful points on the subject of C.P.E.

Whether you are pro or con on this question, C.P.E. appears to be here to stay, and it is increasingly being required as continued recognition by most specialty boards. Even now in some states proof of C.P.E. is required for relicensure.

Exotic trips to far-away places under the guise of C.P.E. are "rip-offs" that will probably not be allowed indefinitely by IRS. Medical meetings covering a wide variety of subjects — something for everyone — afford only a few of interest to each individual, and again there is no evidence to substantiate their comprehension.

Each of us is something of a specialist, regardless of our type of practice. It is surprising how few of the subjects listed in most of the refresher courses are interesting to me as a general practitioner, and it seems a waste of time to attend a two-day meeting with only two hours devoted to topics useful to an individual.

Many Journals are now offering short refresher courses on varied topics, and the only costs are for computer grading — a minimal charge compared to the expense of most meetings. This gives concrete evidence of comprehension. This, or similar approaches, makes required C.P.E. available to all, at the convenience of each physician and at modest cost.

Ability and clinical judgment are being assessed through PSRO and medical audits. These are definitely positive steps, and as physicians realize that someone is "looking over their shoulders," the effect can only be a positive one.

Also, doctors are now much less reluctant to expose "bad medicine" in their peers, partly because of changes in laws and partly because of malpractice that increases the insurance rates for all. Hospitals are more insistent on better quality care, both because of third party demands and the threat of liability claims.

If any individual has constructive criticism on the subject of C.P.E., now is the time to be heard.

W. MONCURE DABNEY, M.D.
Editor
Crystal Springs, MS

LETTERS

SIRS: Schools are commonly regarded as major sites of measles transmission in this country. Of 41,584 reported measles cases in 1977 for whom the age of patients was known, 34,163 (82.2 per cent) were in children 5-19 years old; most (57 per cent, were in the 10 to 19-years-old category.

In recent years, increasing attention has been paid to requirements for a history of measles or measles

immunization for children entering school. Such requirements currently exist in 49 states and Washington, DC. In some of these states, these requirements apply to children in upper grades. Effective enforcement of these requirements has been variable; in some cases it has been complicated by absence of a clear allocation of responsibility.

As of Dec. 31, 1977, at least 6 states* were enforcing school measles immunization requirements or measles-related health laws for students beyond entry level, to the extent of excluding those students who could not document their immune status.

Before enforcement (1975-1976), reported measles incidence rates in these 2 groups of states were similar. During the first 31 weeks of 1978 reported measles incidence rates in the 6 states enforcing their laws (2.7 cases/100,000 population <18 years old) were 92.3 per cent less than the rate in the rest of the United States (35.2 cases/100,000 population <18 years old), according to the Immunization Division, Bureau of State Services, CDC.

The existence of school immunization requirements within states has previously been demonstrated to correlate with a measles incidence rate that is approximately 55 per cent of that in states without requirements. Children in areas that have enforced these requirements are therefore at lower risk of measles and its complications.

Other approaches, in addition to exclusion from school, can be used to improve compliance with state requirements. In Tennessee, for example, the State Departments of Education and Public Health will be cooperating in arranging an enforcement system whereby school children without proof of adequate immunization "will not be counted in the average daily attendance of students for the distribution of state school funds."

Published experience with enforcement program in Alaska, Los Angeles and Detroit (the latter affecting primarily kindergarteners) indicates that necessary immunizations are quickly obtained by most delinquent pupils and that exclusion from school for significant periods is uncommon.

DURWARD BLAKEY, M.D., Director
Bureau of Disease Control
State Board of Health
P.O. Box 1700
Jackson, MS 39205

* Alaska, Colorado, Hawaii, Maryland, New Mexico, South Dakota.

DEATHS

BEASLEY, JAMES M., Senatobia. Born Calhoun City, MS, Jan. 13, 1930; M.D., University of Mississippi School of Medicine, Jackson, 1964; interned Mobile General Hospital, Mobile, AL, one year; died Aug. 8, 1978, age 48.

BRUMFIELD, ROBERT HUGH, McComb. Born Mt. Olive, MS, Aug. 11, 1901; M.D., Tulane University School of Medicine, New Orleans, LA, 1924; interned Touro Infirmary, New Orleans, one year; Emeritus and Fifty Year Club member of MSMA and AMA; died Aug. 17, 1978, age 77.

POWELL, JOHN E., Houlka. Born Vardaman, MS, Jan. 7, 1930; M.D., Southwestern School of Medicine, Houston, TX, 1956; interned Baylor University, Dallas, TX, one year; died Sept. 7, 1978; age 48.

NEW MEMBERS

CROWSON, THOMAS D., Meridian. Born Pontotoc, MS, Jan. 16, 1941; M.D., University of Mississippi School of Medicine, Jackson, 1970; interned Charlotte Memorial Hospital, Charlotte, NC, one year; internal medicine residency, UMC, Jackson, MS, 1971-74; elected by East Mississippi Medical Society.

IRBY, BRAXTER P., JR., Brookhaven. Born Grenada, MS, Oct. 22, 1944; M.D., University of Mississippi School of Medicine, Jackson, 1971; interned UMC, Jackson, MS, one year; internal medicine residency, same, 1972-74; elected by South Central Medical Society.

SALTZ, ISAAC HARRY, Osyka. Born Baton Rouge, LA, Jan. 8, 1920; M.D., Louisiana State University School of Medicine, New Orleans, 1954; interned Touro Infirmary, New Orleans, one year; surgery residency, same, 1964-68; elected by South Central Medical Society.

POSTGRADUATE CALENDAR

Nov. 10, 1978
UPDATE: PITUITARY SYMPOSIUM
University Medical Center, Jackson

Sponsored by the University of Mississippi

School of Medicine Department of Neurosurgery, the Mississippi Neurosurgical Society and the University Medical Center Division of Continuing Health Professional Education.

Coordinators: Robert A. Sanford, M.D., assistant professor of neurosurgery, and Robert R. Smith, M.D., professor of neurosurgery, University of Mississippi School of Medicine.

The symposium will focus on diagnosis and treatment of pituitary tumors. Clinical features and techniques used in the diagnosis of pituitary diseases will be reviewed and updated. The course is for endocrinologists, internists, radiologists, neurologists and neurosurgeons. Fee: $30.00. Credit: 6 contact hours, .6 CEU; Category I, AMA.

Nov. 10-12, 1978
FAMILY PRACTICE UPDATE
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Family Medicine and the University of Mississippi Medical Center Division of Continuing Health Professional Education. Coordinator: Ian Cameron, M.D., assistant professor of family medicine, University of Mississippi School of Medicine.

This three-day course is offered as a refresher for primary care physicians. Discussions will cover new developments in patient care. Fee: $85.00. Credit: 18 contact hours, 1.8 CEU, Category I AMA; AAFP.

Dec. 2, 1978
DIAGNOSIS, TREATMENT AND REHABILITATION OF PATIENTS WITH UPPER LIMB PROBLEMS
Methodist Rehabilitation Center, Jackson

Sponsored by the Mississippi Methodist Rehabilitation Center, the University of Mississippi School of Medicine Department of Surgery and the University Medical Center Division of Continuing Health Professional Education, in cooperation with the American Society for Surgery of the Hand.

Coordinator: Charles W. Emerson, M.D., assistant professor of surgery (orthopedics), University of Mississippi School of Medicine, and chief of Hand and Upper Extremity Service, Mississippi Methodist Rehabilitation Center.

Open to primary care and emergency room physicians, physical therapists and occupational therapists, the course will cover all phases of upper limb care. Dr. John S. Gould, chief of the hand surgery section and associate professor of orthopaedic surgery, University of Alabama, is guest faculty. Fee: $15.00. Credit: 5 contact hours, .5 CEU, Category I AMA; American Society for Surgery of the Hand.

Jan. 8-12, 1979
PRACTICE OF ELECTROCARDIOGRAPHY
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine and the University Medical Center Division of Continuing Health Professional Education.

Coordinator: Thomas M. Blake, M.D., professor of medicine and chief of the Cardiology Division and of Electrocardiography, University of Mississippi School of Medicine.

Designed for the physicians who use electrocardiograms in their daily work, the course will include sessions on mechanism, structure and function. New methods will be discussed with emphasis on computer use. The course is limited to eight participants. Fee: $150.00. Credit: 40 contact hours, .4 CEU, Category I, AMA; AAFP credit applied for.

FUTURE CALENDAR

Feb. 3-4, 1979
MANAGEMENT: A KEY TO SUCCESSFUL MEDICAL PRACTICE
University Medical Center, Jackson

All continuing education correspondence should be addressed to: Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216.

PERSONALS

JOE R. BUMGARDNER of Starkville was inducted as a Fellow of the American College of Surgeons at their annual meeting in San Francisco during October.

T. J. BARKLEY of Belzoni was awarded the membership certificate for the Century Club of the University of Tennessee in recognition and appreciation of unselfish support and service to UT. He also re-

ceived the Fifty Year Club gold pin and membership from MSMA and Delta Medical Society.

WALLACE E. CALDWELL of Jackson has joined the Medical Alumni Guardian Society of the University of Mississippi Foundation.

ALTON B. COBB of Jackson, State Health Officer of the Mississippi State Board of Health, is serving as 1978-79 president-elect of the Association of State and Territorial Health Officials. Dr. Cobb will assume the presidency of the nationwide organization of state health officers at its 1979 meeting. He is the first Mississippian to be elected president of the ASTHO.

MAYO FLYNT of Meridian announces the removal of the offices of Mayo Flynt Medical and Surgical Clinic, P.A., to 1216 23rd Avenue.

SAMMY A. HAMWAY announces the opening of his office for the practice of urology at 647 Evelyn in Clarksdale.

DON Q. MITCHELL of Jackson has joined the staff of Howard Memorial Hospital in Gulfport as a consultant in allergy. In addition to his Jackson office, he will maintain an office in the Medical Plaza Building in Biloxi.

ERNEST H. MITCHELL, JR., has associated with PERRIN N. SMITH and CHARLES D. MILES for the practice of obstetrics and gynecology at the Columbus Women's Clinic, Ltd., at 425 Hospital Drive in Columbus.

JOHN P. MLADINEO has associated with Boronow Clinic, P.A. of Jackson for the practice of gynecologic oncology and gynecologic surgery at Suite 304, Medical Plaza Building, 1600 North State Street.

HUGO C. NIEVAS announces the opening of his office for the practice of cardiology and echocardiography at 1308 44th Avenue in Gulfport.

Pathology Laboratories, Ltd. of Hattiesburg, Mississippi (T. F. PUCKETT, R. S. COOKE, J. L. SMITH, and T. G. PUCKETT) announces the association of DONALD E. MATTHIEU, JR. for the practice of anatomic and clinical pathology at No. 1 Medical Boulevard.

JAMES G. RATCLIFF of Brooksville has been elected to the Board of Directors of National Bank of Commerce of Mississippi.

EDWARD F. SBARDELLA, JR., has joined the staff of Howard Memorial Hospital in Gulfport. He is associated with J. ERIC CHRISTMAN for the practice of ob-gyn at 127 Lameuse Street in Biloxi.

JAMES H. SHIRLEY has associated with JOHN W. BOWLIN and FRANK A. NICHOLS of Tupelo for the practice of thoracic and cardiovascular surgery at 810 Garfield Street.

LAWRENCE ZASLOW of Picayune announces the relocation of his office for the practice of allergy to 310 N. Main Street.

THE LITERATURE

Book Review

Mealtime Manual for People with Disabilities and the Aging. Second edition. Compiled by Judith Lannefeld Klinger, O.T.R., M.A., with the Institute of Rehabilitation Medicine, New York University Medical Center, and Campbell Soup Company. Camden, New Jersey, 1978, 269 pages, illustrated. $3.25.

This is not a nutrition or diet manual. It is a compilation of suggestions and implements for making life, especially in the kitchen, safer and easier for the physically handicapped and a collection of recipes, many, if not most, of which have canned soup as an ingredient. There is a list of helpful references and agencies and another of sources and addresses for equipment and tools.

The book has many excellent illustrations and is well-designed, having a ring binding which keeps it flat when open. The high-grade thick paper enhances turning the pages without tearing and the type style is easy to read by those whose visual acuity is normal. Perhaps others should stay out of the kitchen, anyhow.

Mealtime Manual is expensively made and that probably accounts for the canned soup recipes. It is unlikely that this book could have been published to sell for $3.25 without a subsidy.

WILLIAM R. ARMSTRONG, M.D.
Brandon, MS

MEDICAL ORGANIZATION

Medicare Fees Are Lowest in Mississippi

A study published in the Sept. 22, 1978, issue of the *Journal of the American Medical Association* reveals that Mississippi ranks last among the states with respect to Medicare payments for physicians' services.

The study titled "Geographic Variation in Physicians' Fees" found that average Medicare fees paid to specialists in Mississippi were equal to 73 per cent of average Medicare fees paid to specialists nationally.

In Mississippi's sister states of Alabama, Arkansas, Louisiana and Tennessee average Medicare fees were equal to 99, 88, 89 and 94 per cent respectively of the national average.

The study, which was conducted prior to the recent increase in Medicaid fees in Mississippi, also found that the state ranked 48th in Medicaid fees.

Nationally, the study found that Medicaid specialists fees were 77 per cent of Medicare specialists fees and Medicare specialists fees in metropolitan areas were 23 per cent higher than those in nonmetropolitan areas.

Medical Center Releases Registration Figures

One-hundred-and-fifty of the 493 new students at the University of Mississippi Medical Center are first-year students in the School of Medicine. Total medical school enrollment is 607.

The total fall semester roster at the Medical Center is 1,497, a 36 per cent increase over the figure just five years ago.

The sharpest rise in enrollment occurred in the School of Health Related Professions (SHRP) with a 74 per cent increase in the five-year period surveyed. The school registered 162 students this fall including 94 freshmen.

The 1978-79 session marks the first in which all four dental school classes are represented. The school admitted its first class in 1975, and those students expect to receive Mississippi's first dental degrees next spring. Forty-five freshmen bring the total dental school student body to 126.

Nursing school enrollment is 208 including 84 first year students and 33 graduate students.

Seventy students are enrolled in the graduate programs; 59, in radiologic technology, cytotechnology, clinical nuclear medicine and nurse midwifery.

The Medical Center student body number also reflects a postgraduate enrollment of 32 interns, 209 residents, 12 fellows, and 12 clinical psychology residents.

Reporting of Pesticide Incidents Is Urged

The Mississippi Epidemiologic Studies Program is in need of assistance from physicians in Mississippi. The project, located at the State Chemical Laboratory on the Mississippi State University campus, is responsible for implementing the Pesticide Incident Monitoring System (PIMS) in a geographical region which includes Alabama, Kentucky, Mississippi and Tennessee. The study is part of a nationwide effort to determine the effects of pesticides on human health and the environment. It is hoped that all pesticide-related incidents will be documented.

"We feel the request is not unreasonable since the number of poisoning cases seen by any one physician is relatively small," said Larry G. Lane, Ph.D., principal investigator for the program. "We also emphasize that a patient's identity is not needed since we are interested only in the pertinent facts surrounding a poisoning incident: time, place, pesticide involved, occupational relationship, route of exposure, major symptoms exhibited and type of medical treatment administered. Information is requested on all pesticide-related cases including acute, subacute and chronic exposure."

As a service, the program offers the laboratory's expertise in dealing with pesticide poisonings. It provides free cholinesterase determinations and pesticide residue analyses to aid in the diagnosis and confirmation of poison cases. Due to the time and distances involved, these analyses would most likely be performed as confirmatory aids and not in the actual diagnoses. For more information on the program, write or call Dr. Larry G. Lane, Mississippi Epidemiologic Studies Program, Mississippi State Chemical Laboratory, Box CR, Mississippi State, MS 39762, phone (601) 325-4308.

Influenza Vaccine 1978-79 Reported by MSBH

Influenza vaccine for 1978-79 will consist of inactivated trivalent preparations of antigens representative of influenza viruses expected to be prevalent: A/USSR/77 (H1N1), A/Texas/77 (H3N2), and B/Hong Kong/72. Two alternative vaccine formulations will be available for different age groups. The formulation recommended for individuals 26 years and older, most of whom have had prior experience with all 3 viruses, will contain 7 micrograms of Hemagglutinin of each antigen. Only 1 dose is required for members of this age group. In contrast, the formulation recommended for persons less than 26 years of age, most of whom lack contact with H1N1 strains, will contain 20 micrograms of the A/USSR antigen and 7 micrograms each of the other 2 antigens. Persons in this age group will require 2 doses for satisfactory immunization. Both formulations will be available as "whole-virus" and "split-virus" preparations. Only split-virus vaccines are recommended for persons less than 13 years of age. The vaccine dosage, by age, is shown in the table below.

TABLE 1

INFLUENZA VACCINE DOSAGE, BY AGE, 1978-79

Vaccine Formulation	*Age (Years)*	*Product Type*	*Dosage (ml)*	*Number of Doses*
Adult*	>26	whole-virus split-virus	0.5	1
Youth†	13-25	whole-virus or split-virus	0.5	2‡
	<13	N/A§	N/A§	N/A§

* Contains 7 micrograms each of A/USSR/77, A/Texas/77, B/Hong Kong/72 Hemagglutinin antigens.

† Contains 20 micrograms A/USSR/77 and 7 micrograms each of A/Texas/77 and B/Hong Kong/72 Hemagglutinin antigens.

‡ 4 Weeks or more between doses; both doses essential for good protection.

§ N/A = Not available; final recommendations for those <13 years old will be made in approximately 1 month

Current expectations are that Mississippi Immunization Program will file a grant request for vaccine and related support for the state. If the current DHEW appropriation is approved, this should permit acquisition of vaccine in October, according to Durward Blakey, M.D., director, SBH Bureau of Disease Control.

Chamber of Commerce Endorses Carter's Health Principles

The 10 national health insurance principles issued by President Carter have drawn endorsement from the Chamber of Commerce of the United States.

Organization president Richard L. Lesher, in a letter to Mr. Carter, said the principles recognize "the devastating inflationary impact and other harmful results that a massive government health care program would have on our country."

The principles already have been applauded by the health insurance and hospital industries.

UMC Has Pain Clinic

A new multidisciplinary pain clinic at the Medical Center combines medical treatment with psychological help and physical therapy to ease the plight of the chronic pain sufferer.

Dr. Steve Sanders, assistant professor of psychiatry (psychology), says every patient receives a thorough medical, psychological and physical therapy evaluation by the clinic staff.

Until the late 60s he explained, pain was widely viewed solely as a physical event. Now the view has broadened to include emotions and behavior as key elements in the concept. How a person perceives his own pain and how he reacts to it are major factors in the extent of suffering.

In addition to Dr. Sanders, the clinic team includes Dr. Marie Mastria, assistant professor of psychiatry (psychology); Dr. Robert Currier (consultant), neurology department chairman, and Dr. Mike Douglas, assistant professor of neurology; Dr. Dudley Peeler, associate professor of neurosurgery (research), and Dr. Robert Sandford, assistant professor of neurosurgery; Dr. James Hughes, orthopedics division chief, and Dr. Alan Freeland, assistant professor of surgery (orthopedics); Dr. John Forestner, assistant professor of anesthesiology; Carol Schaefer, assistant professor of physical therapy; and Dr. Sarah Allison, director of nursing at the Mississippi Methodist Rehabilitation Center.

Patients are considered clinic candidates if: 1) they suffer from chronic pain (three months or longer duration) which is not responding well to current medical treatment; 2) they are 18 years old; 3) all available medical data suggest that pain is not due to malignant or terminal disease processes; and 4) they are not currently involved in pain-related litigation.

All patients must be referred by their physicians. Physicians may obtain more information from Dr. Sanders in the UMC psychiatry department.



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows.

Possibly Effective.

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily
Intramuscular: 5 to 10 mg (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphtol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 $\mu g/ml$.

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Tennessee PSRO Is Shut Down

Citing "serious financial management problems," the Deparment of HEW has closed a Professonal Standards Review Organization (PSRO) in Tennessee.

The Nashville-located PSRO recently underwent a financial audit which turned up cost overstatements amounting to over $200,000.

The PSRO was administered by the Tennessee Foundation for Medical Care under a $2.5 million contract with the Department of HEW.

Scoliosis Research Society Inducts Dr. H. Brown

At the 13th Annual Meeting of the Scoliosis Research Society in Boston on September 12, Dr. Hugh P. Brown of Jackson was inducted into the Scoliosis Research Society as a fellow.



Dr. Brown

The Scoliosis Research Society, an affiliate of the American Academy of Orthopaedic Surgeons, was formed in 1966 by orthopaedic surgeons throughout the United States and Canada who were interested in research and treatment of scoliosis and other related spinal deformities. The Scoliosis Research Society has promoted school screening for scoliosis throughout the United States.

Dr. Brown is a graduate of University of Tennessee Medical School and completed internship at Wilford Hall USAF Hospital, Lackland AFB, and orthopaedic surgery residency at Tulane Medical School.

UMC Announces New Faculty Members

An assistant professor and three instructors have joined faculties at the University of Mississippi Medical Center.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced the appointments following approval by the Board of Trustees, State Institutions of Higher Learning.

In School of Medicine appointments, Dr. John Duncan Abernethy was named assistant professor of medicine and Dr. Paul Harmon Parker was named instructor in pediatrics. New centerwide members are Dr. George P. Allen, instructor in microbiology, and Dr. Vimochini Suvarna, instructor in pathology.

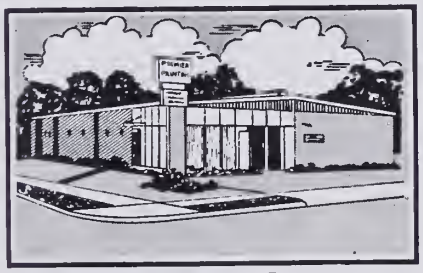
Dr. Abernethy, a resident at Mt. Sinai (N.Y.) Medical Center since 1977, is a graduate of New Zealand's University of Otago Medical School. He interned at Dunedin Hospital in New Zealand, and held fellowships at Southern University of New York in Buffalo and at the Australian National University. Study director of the national blood pressure study in Australia from 1973-1977, Dr. Abernethy is a former medical officer for the Australian Department of Health, and served as medical registrar at St. Olave's Hospital in London.

Dr. Parker, a resident in pediatrics at UMC since 1975, earned the B.S. degree at the University of Mississippi in 1971. He earned the M.D. degree at the Medical Center in 1975.

Dr. Allen, a postdoctoral fellow at UMC since 1975, earned the B.S. degree at Georgetown (Kentucky) College, and the Ph.D. degree at the University of Kentucky. He was a bacteriologist at the University of Cincinnati Medical Center from 1966-1968, and on the research staff at the Univer-

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sity of Kentucky Medical Center from 1968-1970.

Dr. Suvarna, an associate in pathology at UMC since July, earned the M.D. degree at the University of Mysora in India in 1970. He took residency training at Albany (N.Y.) Medical College and at Creighton University Medical Center in Omaha.

Aspirin MI Study Reports Results

Entering the last stretch of the Aspirin Myocardial Infarction Study (AMIS), University of Mississippi Medical Center study director Dr. Richard Hutchinson reports lower-than-average dropout and mortality rates.

The study began in 1974 and will end in 1979.

"We've had only three patients out of 150 drop out and the expected dropout rate by now would have been 7-8," said the associate professor of medicine.

He credits Jane Johnson, project coordinator, Faye Blackburn, technician, and Dr. Claudia Beghe, UMC instructor in medicine and co-investigator, with keeping enrollment high. "They all show a sincere personal interest in every volunteer, and I think that's the key factor."

Only seven participants have died since the study began, Dr. Hutchinson noted. Based on statistics, the expected number was 14 by this time.

He attributes the low mortality rate to the close follow-up care participants get both by their personal physicians and the AMIS staff.

The AMIS, funded by the National Heart and Lung Institute, is designed to provide sound statistical data to test aspirin's effectiveness in preventing recurrent heart attacks.

All 4,300 volunteers in 30 of the nation's medical centers have had at least one heart attack. Half the group takes aspirin; the other half takes a placebo. Neither participants nor investigators know who gets what until the end of the study.

The present study was conceived after results of the Coronary Drug Project Aspirin Study in 1973 showed a 30 per cent reduction in mortality in participants who took aspirin.

"Statisticians weren't satisfied with the results because the patients weren't entirely typical heart attack victims, and had earlier all taken other coronary drugs beside aspirin as part of the original study."

As reflected in the local phase of AMIS, directors tried to recruit volunteers to represent a cross section of the population. "Our patients come from every spectrum of society — and from varied occupations. The group includes veterinarians, mechanics, housewives, businessmen, realtors, farmers, and retired military personnel."

In addition to testing aspirin's effectiveness, the study will yield information about possible health problems resulting from prolonged daily use of aspirin.

In order to keep the study "clean" no one known to be an habitual aspirin user was enrolled. "We eliminated anyone with a condition, like arthritis, which might call for aspirin on a regular basis."

Volunteers get plenty of aspirin substitute for occasional use for headaches and other minor pain, however.

To maintain the double blind, random urine samples are sent to a central project lab to check for aspirin content. "The samples allow the lab to check adherence in the aspirin group and non-compliance in the placebo group."

Positive results in this study will not prove that aspirin will prevent an initial heart attack, Dr. Hutchinson said. But favorable results could mean a significant breakthrough in the treatment of heart disease.

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Nancy Tatum Wins UMC Ciba Award



Nancy O'Neal Tatum received the 1978 University of Mississippi Medical Center CIBA Award for outstanding community service. CIBA Pharmaceutical Company representative Burt Hardey presented Ms. Tatum a set of Netter anatomy atlas volumes. Medical students select a classmate for the award. Ms. Tatum, the daughter of Dr. and Mrs. A. T. Tatum of Hattiesburg, is a junior in the UMC School of Medicine.

Upper Extremity Problems Studied at UMC

Primary and emergency room physicians, occupational and physical therapists, and other health professionals may participate in a seminar on upper extremity problems Dec. 2.

Sponsors are the University of Mississippi School of Medicine Department of Surgery, the UMC Division of Continuing Health Professional Education and the Mississippi Methodist Rehabilitation Center, in cooperation with the American Society for Surgery of the Hand.

The one-day course, at the Mississippi Methodist Rehabilitation Center, is designed to give a better understanding of the diagnosis, treatment and rehabilitation of patients with upper limb problems. Participants are encouraged to bring x-rays and case histories for discussion.

On the program are Dr. John S. Gould, chief of the hand surgery section and associate professor of orthopedic surgery, University of Alabama in Birmingham; and Lois Day, therapist at the Methodist Rehabilitation Center.

Course fee is $15.00. Registration is limited and advance registration required. The course carries 5 credit hours (.5 CEU) in Category 1 of the Physician's Recognition Award of the American Medical Association.

For more information, contact the Division of Continuing Health Professional Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216.

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Medical Center Hosts Allergy Workshop



Some 50 physicians attended the September allergy workshop for the generalist at the University of Mississippi Medical Center. Dr. Bernard Booth, center, UMC clinical associate professor of medicine, was course coordinator. Among the guest faculty were, from left, Dr. Samuel R. Marney, Vanderbilt University, Nashville; Dr. Philip Lieberman, University of Tennessee Center for the Health Sciences College of Medicine, Memphis; Dr. Elliot F. Ellis, State University of New York at Buffalo; and Dr. Raymond G. Slavin, St. Louis University Medical School. Vanderbilt University School of Medicine and the University of Tennessee Center for the Health Sciences College of Medicine were cosponsors.

Neurological Update Is Scheduled

The sixth annual neurological update symposium is set for Jan. 29-Feb. 2, 1979. The sponsor is the University of Miami School of Medicine Department of Neurology.

The course will be held at the Konover Hotel, Miami Beach.

For further information, contact the Division of Continuing Medical Education D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami, FL 33101.

SMA-MAG Scientific Assembly Set for Atlanta, November 11-14

Dr. Jay P. Sanford, dean of the new Medical School of the Uniformed Services of the Health Sciences, Bethesda, and Dr. Arthur H. Keeney,

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Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension if this complicates Tenuate overdosage.

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References: 1. Citations available on request – Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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dean of the University of Louisville Medical School, will head a list of nationally and regionally known speakers addressing the first joint Scientific Assembly of the Southern Medical Association and the Medical Association of Georgia, Nov. 11-14, at the Georgia World Congress Center in Atlanta.

Over 3,000 physicians from 16 southern states and the District of Columbia are expected to attend.

New concepts and treatments in 23 medical specialties will be covered in the four-day meeting, to include 17 postgraduate courses.

The event marks the 72nd annual scientific assembly of the SMA, second largest medical organization in the country, encompassing over 25,000 members.

Dr. Andrew F. Giesen, Jr. of Ft. Walton Beach, FL, SMA president, describes the interdisciplinary program as "the widest selection of clinical material of any scientific meeting in the country." Dr. Thomas B. Dameron, Jr. of Raleigh, NC, will be installed as 1978-79 president during the Atlanta meeting.

Dr. C. H. William Ruhe, senior vice president for scientific activities of the American Medical Association, will give the 1978 Abner W. Calhoun Lecture at the MAG luncheon, Nov. 11. His topic is "1984: Nightmare or Utopia for Medical Education?"

Topics for discussion will range from "The Role of Cingulotomy in the Treatment of Psychiatric Illness" by Dr. H. Thomas Ballantine, Jr., senior neurosurgeon of Massachusetts General Hospital, to "Behavioral Approaches to the Headache" by Dr. Redford B. Williams, Jr. of the psychology and medical faculty of Duke University.

Dr. James E. George of Woodbury, NJ, a physician and attorney, will speak on "law and Emergency Medicine" to members of the organization's new Section on Emergency Medicine.

The use of intraocular lenses in eye surgery, replacement hip arthroplasty, antibiotics in pregnancy, hyperkinesis in pediatric patients, and tumors of the testis will be among 400 noteworthy medical topics on the agenda.

Other leading educators on the program — all chairmen of departments in medical schools — include: Dr. Donald J. Birmingham, dermatology and syphilology, Wayne State University; Dr. C. McCollister Evarts, surgery, University of Rochester; Dr. James D. Hardy, surgery, University of Mississippi; and Dr. William Staubitz, urology, and Dr. Richard H. Schwarz, obstetrics and gynecology, State Universities of New York at Buffalo and Brooklyn, respectively.

Societies meeting concurrently are: the Southern Chapter, American College of Chest Physicians; American Fertility Society; Society for Investigative Dermatology; Southern Gynecological and Obstetrical Society; and Radiological Society of North America.

The assembly is approved for Category 1 credit toward the AMA Physicians' Recognition Award and offers 77 prescribed and 168 elective hours credit to members of the American Academy of Family Physicians.

Skateboarding Safety Rules Are Listed

Skateboarding now claims 20 million enthusiasts in the United States. It also is the source of many injuries.

Guidelines for safer skateboarding are offered by two Detroit doctors in an article in the August issue of the *American Journal of Diseases of Children,* a scientific publication of the AMA. The guidelines stem from treating 30 fractures from skateboarding falls in a period of six months at Detroit's Henry Ford Hospital.

Drs. Richard W. Hawkins and E. Dennis Lyne recommend:

1. Use proper equipment. Buy a well-made board, selected to fit size and age of the rider.

2. Keep the board in good working order. Examine the board, wheels and trucks frequently and make repairs as needed.

3. Protective clothing, including helmet, tennis shoes, knee pads and gloves, should be worn at all times. Long trousers and long-sleeved shirts will cut down on cuts and abrasions.

4. Know your skateboarding route, and check it for stones, cracks or possible obstructions.

5. Be aware of local ordinances prohibiting skateboarding in certain areas. Avoid skating on city streets at all costs.

6. Master the basic skills before attempting more difficult maneuvers.

7. Hold down speed so that the skateboard is under control at all times.

8. Do not permit children to be towed by bicycles or other vehicles.

9. Children must demonstrate balance and coordination, such as in bicycling, before being allowed on a skateboard.

10. Instruction in proper falling and rolling techniques will help reduce injuries, especially to the outstretched arm.

11. Skate only when in good physical condition and after completing warmup exercises. Do not skate when fatigued.

Christmas Seals Sponsor Asthma Information Seminar

An asthma information seminar, sponsored by the Mississippi Thoracic Society and the Mississippi Lung Association, was held recently at the Coliseum Ramada Inn, Jackson.

The seminar was designed to provide general information on asthma to patients, parents, friends and other individuals interested in learning more about the nature, causation and control of this condition.

"Why Does Joe Wheeze," "Why Does Your Child Wheeze" and "Living with Asthma" were some of the topics presented by panel members — physicians, allergists, non-professionals and asthmatics.

Following the panel presentations, participants were given the opportunity to be involved in table discussion groups concerned with understanding asthma and how to deal with it in the context of today's lifestyle. Topics presented included, "Drugs, Old and New," "Asthma in Children" and "Asthma in Athletics and Exercises."

Dr. G. Boyd Shaw served as chairman of the planning committee. Other committee members and participants included Drs. Joe R. Norman, M. D. Hardy, Jr., Wilfred Q. Cole, Guy D. Campbell, Bernard H. Booth, Barry Whites, Suzanne Miller, A. Wallace Conerly, James Griffith and John Wofford.

The seminar, part of the educational service of the Christmas Seal voluntary health organization to prevent and control lung diseases and respiratory problems, was a pilot project and planned so that it may be used for similar sessions throughout Mississippi.



Athletes, parents and coaches took part in the group discussion concerning "Asthma in Exercises and Athletics." Panelists were (from left) Dr. John Wofford, Dr. A. Wallace Conerly, Dr. G. Boyd Shaw and Dr. James Griffith.



Conference chairmen for Asthma Information Seminar included (from left) Dr. Joe R. Norman, presider, Dr. Wilfred Q. Cole, panel discussion leader, and Dr. G. Boyd Shaw, seminar chairman.

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Index to Advertisers

Beltone Electronics Corp. **8**
Bryant Bureau **7**
Burroughs Wellcome Co. 220B

Canton Exchange Bank **7**
Citizens Bank and Trust Co. **11**
Coca-Cola **11**
Consolidated Capital 218

Emergency Physicians **19**

Fairfield Bay Medical Center **19**

Guaranty Properties Bay Colony **12**

Harreld Chevrolet-Oldsmobile 222
Hill Crest Hospital **14**

JADAM Leasing, Inc. 219

Eli Lilly and Co. **18**

Mead Johnson Pharmaceutical Division 217A, 217B
Merrell-National, Inc. **14B, 15, 16,** 220, 220A
Mississippi Stationery Co. **19**

Premier Printing Co. 217

Richardson-Merrell, Inc. **6B**
Riverside Hospital 207
Roche Laboratories
..... **second cover, 3, 4, 6, 6A, third and fourth covers**

Roerig and Co. (Div. of Pfizer Pharm.) **10, 10A**

Smith Kline and French **14A**

The Upjohn Co. **10B**

Thomas Yates and Co. **17**

IN CONCLUSION

Two studies should be made before the Guide to Drug Prices becomes a permanent federal publication, the AMA said of HEW's proposed drug price catalog. When announcing plans for the Guide, HEW Secretary Joseph Califano said it "should allow doctors and pharmacists to take costs into account when prescribing and ordering prescription drugs." The AMA recommended a study to determine the correlation of pharmacy acquisition costs with retail prices and the relationship of pharmacy location and acquisition costs.

Aspirin poisonings in children have dropped from first to fourth place on the list of causes of poisonings among children age 5 and under. According to the I.U. Institute for Research in Public Safety, first place is now occupied by house plants-- dieffenbachia holly berries, pyrocantha (firethorn), poinsettia, pokeweed, woody nightshade, African violet, Jerusalem cherry, black elder and begonia. Other poisons are soaps, detergents and cleaners (second place), vitamins and minerals are third and antihistamines and cold medicines are fifth.

Americans have better access to medical care than ever before, says Center for Health Administration Studies of the University of Chicago. Seventy-six per cent of Americans saw a doctor in 1976, according to the report reviewed by the Health Insurance Institute. More than 70 per cent of low-income Americans ($7,999 per year per family) saw a doctor in 1976 compared with little more than half in 1963. Among blacks, some 75 to 80 per cent see a physician at least once a year now (about the same rate as for whites) compared with only 50 per cent in 1963.

Twenty-five per cent of hospital costs in New York can be traced to compliance with government regulations, according to testimony from the Hospital Association of New York before the Senate Judiciary Committee. A two-year study of 150 hospitals shows New York hospitals spent more than $1.1 billion to satisfy regulations of 164 different regulatory bodies. These included 96 state agencies, 40 federal, 18 local and 10 quasi-public. The American Hospital Association concludes that at least $22 per visit to the hospital could be traced to regs.

HEW Secretary Califano announced next year he will develop grants and contracts to pay for care of the terminally ill--not now covered under Medicare or Medicaid. He revealed plans for custodial home care, drug reimbursement and payments for bereavement counseling at the first annual meeting of the National Hospice Organization, which specializes in counseling and facilities for the dying. Califano didn't mention that his hospice plan already has been approved in Medicare amendments passed by the Ways and Means.

Before prescribing, please consult complete product information, a summary of which follows:

The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets in children under 6 months of age, known hypersensitivity, acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients, should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V. inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status.

Withdrawal symptoms (similar to those with barbiturates, alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal/muscle cramps, vomiting, sweating). Keep addiction-prone individuals under careful surveillance because of predisposition to habituation/dependence. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary, not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site; hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

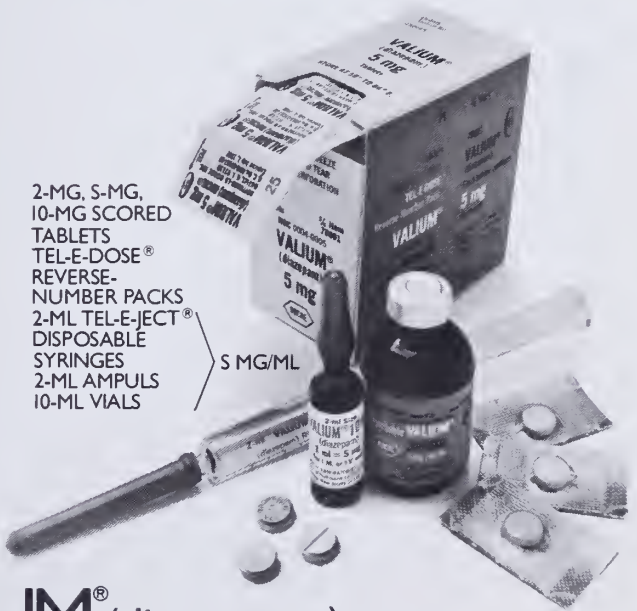
In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure, employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects. Dialysis is of limited value.

Supplied: Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500, Tel-E-Dose* (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Ampuls, 2 ml, boxes of 10. Vials, 10 ml, boxes of 1. Tel-E-Ject* (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

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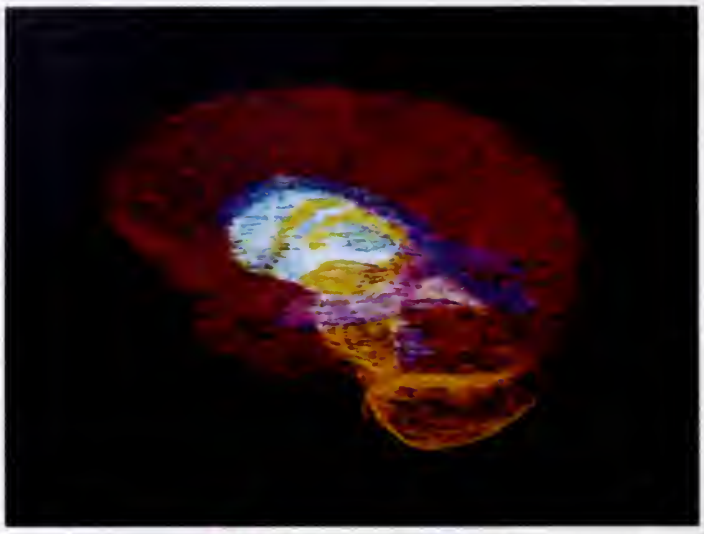


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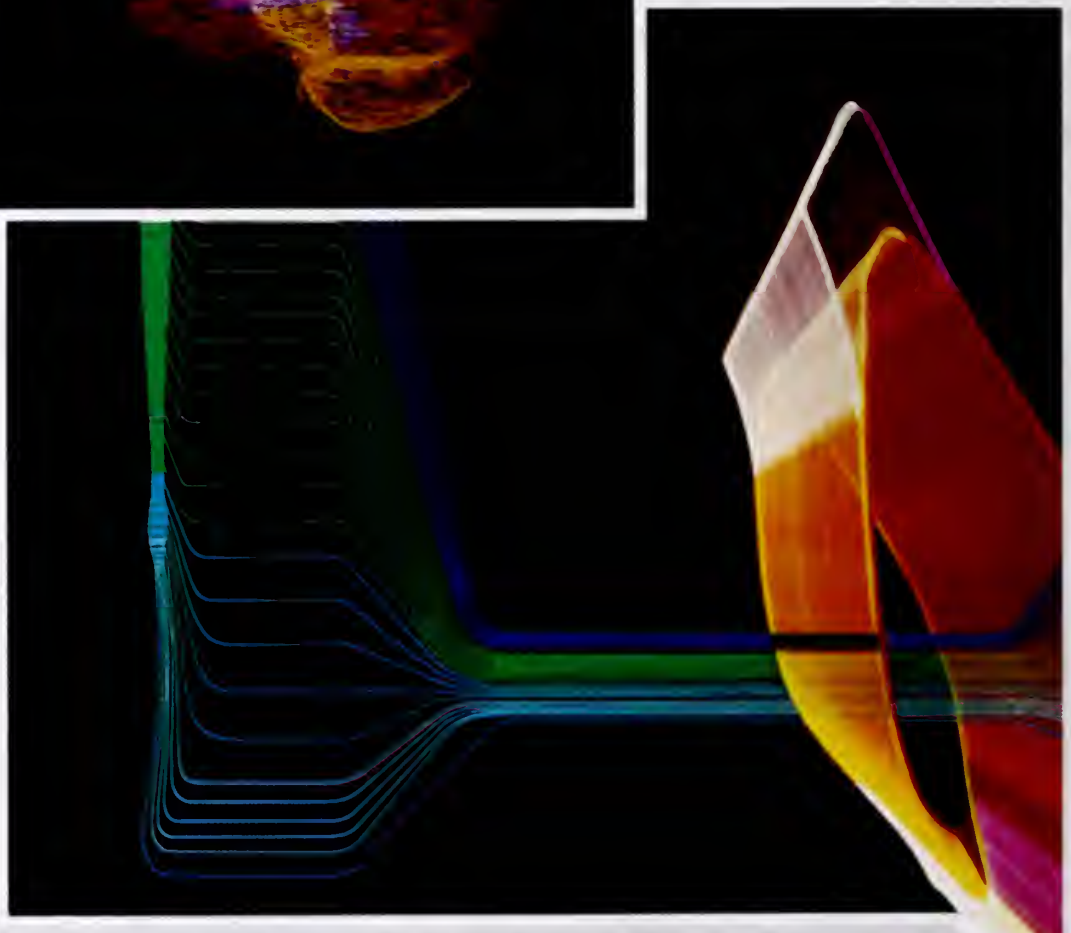
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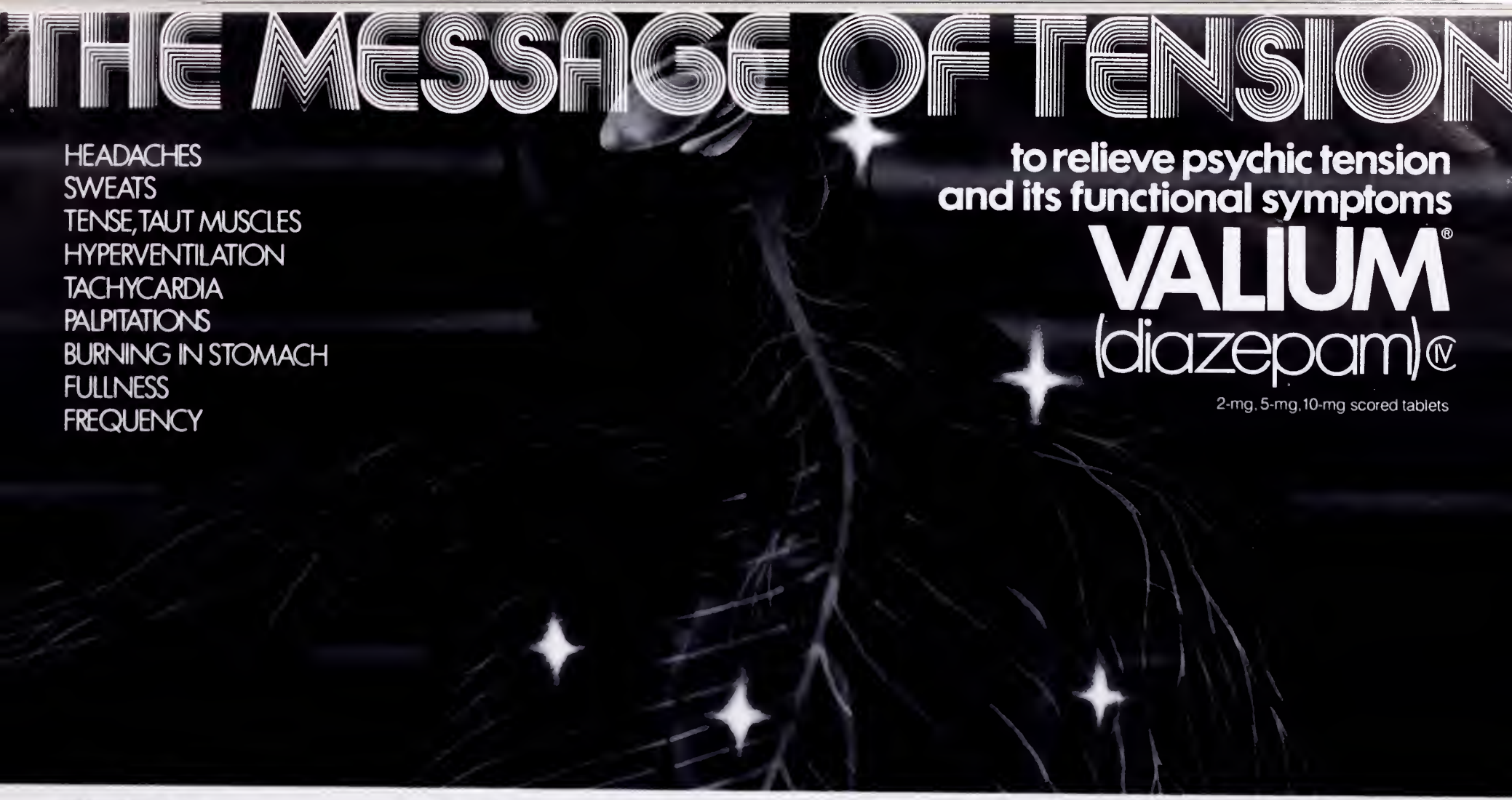


Contents:

Tubular Hindgut Colonic Duplication

Aging and Mental Health

The Transient Ischemic Attack Pitfall



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Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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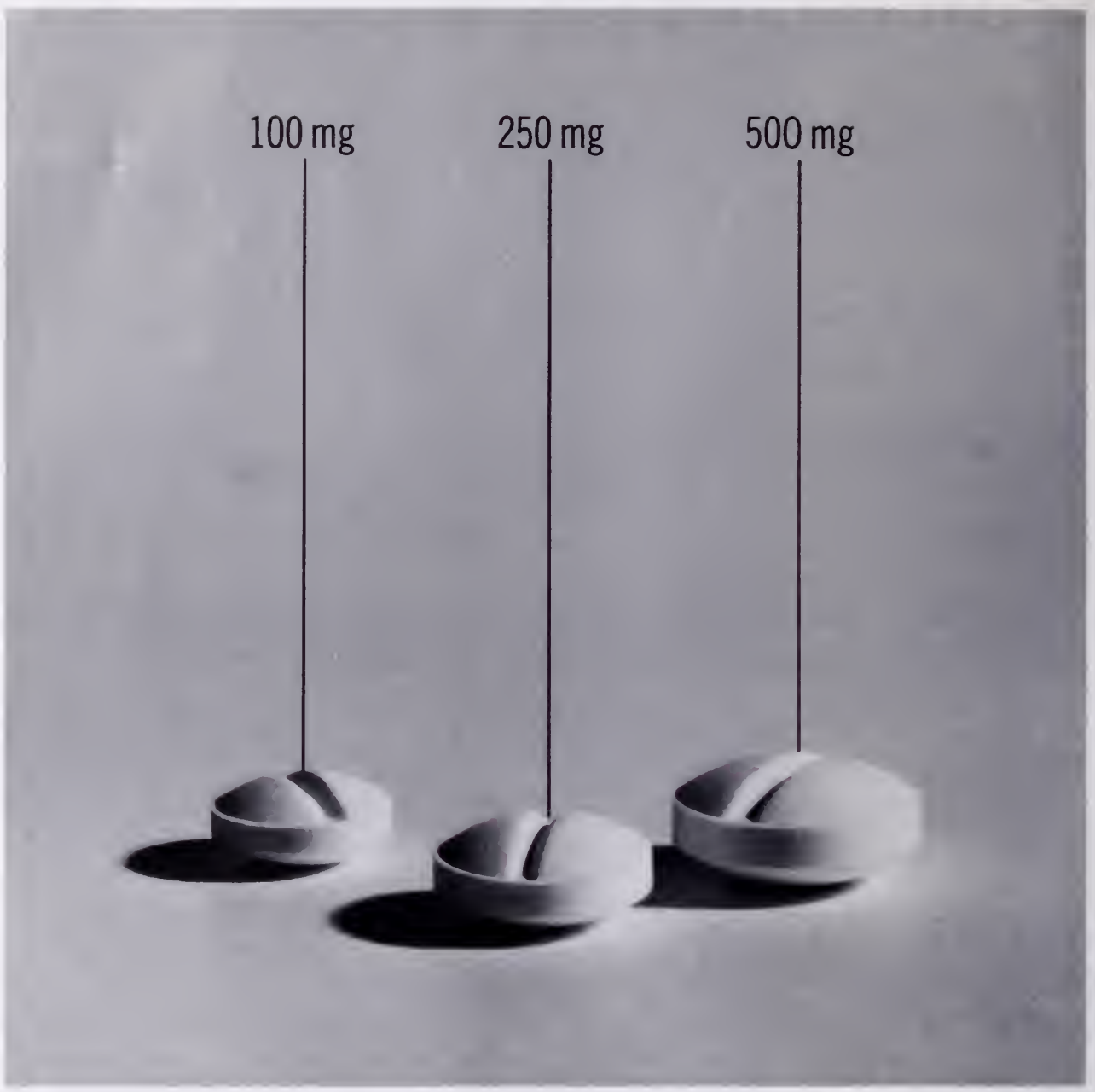
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CONTENTS

ORIGINAL PAPERS

Tubular Hindgut Colonic Duplication: Report of a Case — **223** J. Preston Hughes, M.D., and John E. Ray, M.D., New Orleans, LA

Aging and Mental Health — **226** B. Frank Vogel, M.D., Hattiesburg, MS

SPECIAL ARTICLES

Radiologic Seminar CLXXXVII: The T.I.A. Pitfall — **228** Allen R. Yates, M.D., and Douglas R. Stringer, M.D., Jackson, MS

Finch Atop Health Planning Pyramid — **230** Edith Bierhorst Back, Biloxi, MS

EDITORIAL

Saved by the Bell — **235** George H. Martin, M.D., Vicksburg, MS

THIS MONTH

Auxiliary Page—The President's Report — **233** Mrs. G. Samuel Rowlett, Jr., Vicksburg, MS

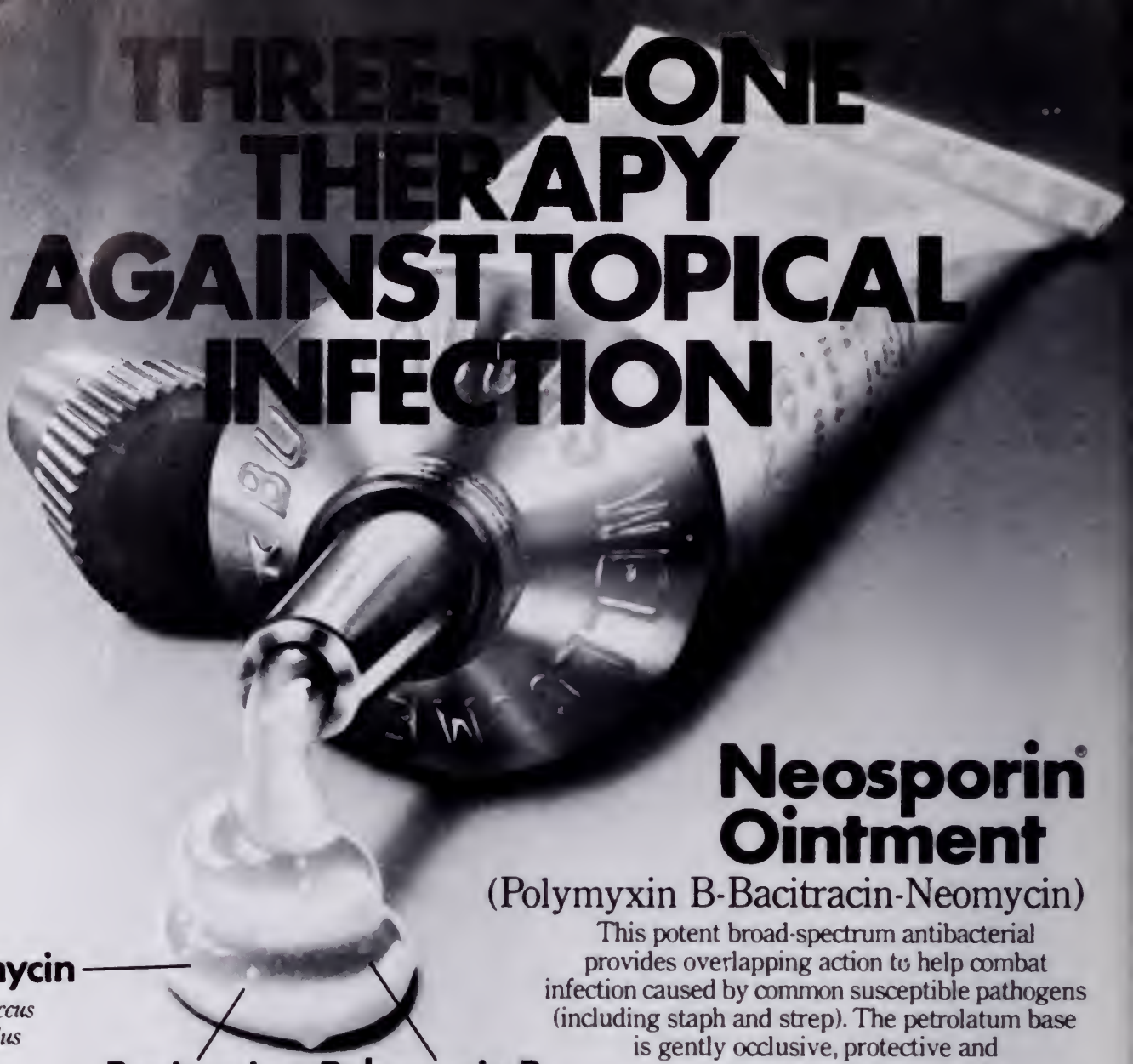
The President Speaking — **234** Medical Care Costs—A Public Concern

Medical Organization — **239** 1979 MSMA-Robins Award Is Announced

1978 Volume Index — **243** Annual Publication

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching, it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

The Physician Supply Peaks

The supply of physicians will be more than adequate to meet the nation's needs by 1990, according to a government study.

"Tremendous increases in health manpower supply (may) bring supply and requirements for most health professions more nearly into balance then at any time in the nation's recent history," said the report on the Status of Health Professions Personnel in the United States, prepared by the Department of HEW. The increases stem from the sharp expansion of training facilities and enrollments during the past decade due in part to federal programs to aid medical education.

The numbers of practitioners in the major health professions — medicine (including osteopathy), dentistry, optometry, pharmacy, podiatry and veterinary medicine — are expected to increase from 40 per cent to 70 per cent between 1975 and 1990. In every discipline the supply is expected to increase faster than the population.

Physician supply is expected to rise from 379,000 in 1975 to almost 600,000 in 1990. The ratio of physicians to population is projected to rise from 177 per 100,000 people in 1975 to 241 per 100,000 in 1990.

Medical Office Managers Meet in Atlanta

The Medical Association of Georgia, in cooperation with the AMA, will present a workshop for medical office managers, "Team Building — A Better Way to Supervise," Tuesday, Jan. 30, 1979, at Ramada Inn Central, Interstate 85 North at Monroe Drive, in Atlanta.

Faculty will be from the Department of Practice Management, American Medical Association.

Registration fee is $50 per person and enrollment is limited to the first 35 registrants.

Contact Sue McAvoy, Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, GA 30309, 404-876-7535, 800-282-0224 (toll-free), for further information.

The seminar will cover recruiting, interviewing, and selecting employees; developing meaningful job descriptions and personnel policy handbook; motivating and coaching employees to be "key players"; job performance review, terminating an employee, and salary review; and better communication through effective staff meetings and training. This workshop is designed for persons who are presently in a supervisory or management position. It is not for *non-supervisors*.

Health Costs Issues Are Defeated

In spite of nationwide voter popularity of various ballot issues in the November elections to reduce taxes and governmental costs, proposals to limit health care spending failed to gain public support.

Perhaps the most serious effort to reduce health care costs took place in North Dakota where a proposal to set maximum rates for hospital, physician and other health services appeared on the ballot. The proposition was strongly pushed by the Teamsters and Farmers Unions in the name of doing for health care costs what California Proposition 13 had done for property taxes. It failed by a substantial margin even though the same voters endorsed a measure to cut state income taxes by a 2 to 1 margin.

In a similar vein, voters in Arkansas refused to repeal the state's three per cent sales tax on drugs. But in Oregon dentists did take a somewhat "cut health costs" defeat as voters approved having non-dentists called "denturists" fit and install false teeth.

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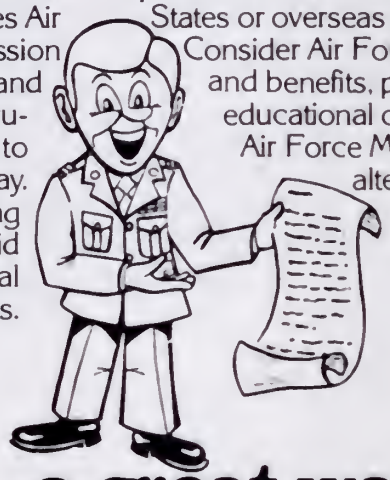
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NEWSLETTER

December 1978

Dear Doctor:

AMA witnesses told the Senate Human Resources Subcommittee on Health that the national health insurance plan developed by Sen. Edward Kennedy (D-Mass.) and organized labor would result in a "federal takeover" of the health care system and would "not be in the interest of the citizens of this country." AMA spokesmen said, "The history of federally run programs does not instill such trust and confidence as to support such action."

> Another witness, HEW Secretary Califano said the plan was too costly, pointing to the $30.8 billion it would add to the federal budget in 1983. He said any program "must be phased in with singular care and sensitivity to the economy, governmental budget, and administrative complexity of the health care system."

The National Health Planning and Resources Development Act, up for renewal, failed to pass the 95th Congress, but it will be re-entered in the 96th Congress when it convenes January 15. Money to run the agencies was provided in a six-month continuing resolution in the Labor-HEW appropriations bill. Other bills that will be back next year include hospital cost containment and Medicare amendments.

It's not medical care that is growing faster than the Gross National Product. It's outlays for 41 federal regulatory agencies, contends Murray L. Weidenbaum, director, Center for Study of American Business, Washington University. He's stumping the nation urging a "regulatory revolt" as the next step after the Tax Revolt. See the October issue of Nation's Business and Citizen's Choice for more on his revolt.

A cost containment checklist has been prepared for physicians. The checklist, in brochure form, lists more than 30 suggestions for physicians to consider in attempting to hold down the cost of health care in both the hospital and the office settings. The bruchure will be mailed to every member of the Mississippi State Medical Association in the December "Blue Sheet."

The coronary bypass operation is being used with increasing frequency but the relative benefits of this procedure--length and quality of life and working status--are still being debated. The bypass surgery is expensive; a recent study reported in JAMA revealed that the average total hospital and physician cost was $10,930 and average length of hospital stay is 18 days.

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Nola Gibson
Managing Editor

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Physician Recruiting Ads Are Mere Puffery

A military lawyer serving as prosecutor in a court martial proceeding against an Army physician has called recruiting ads for physicians "puffery" and "simply braggings on the part of the government" rather than promises that must be kept.

The physician in the case, Captain Leon T. Davis, is being prosecuted for his refusal to continue practicing on the grounds that the Army failed to live up to its recruiting promises.

Dr. Davis claims that he is no longer in the Army and should not be court martialed because the Army broke its contract with him for medical services by failing to provide modern equipment, equal pay for equal work, 30 days vacation annually and time to attend medical meetings, as advertised.

"These were simply braggings on the part of the government and not actual contractual right" the Army prosecutor contended, which Dr. Davis could not be so "naive" as to take serious.

Mississippi Medical Assistants Attend National Meet

Attending the 22nd Annual Convention of the American Association of Medical Assistants at the Sheraton-Boston Hotel, Oct. 23-28, were Martha King of Tupelo and Carol Lockey of Jackson, state delegates and Ethel Tatum of Meridian, state president.

These medical assistants, educators and students, along with physicians and other interested individuals, enjoyed a wide range of educational experiences dealing with both the administrative and clinical aspects of medical assisting. Sessions of general interest addressed such topics as early New England medicine and interpersonal relations in the medical office, while special-interest sessions ranged from office administration and management to microbiology and specimen collection and preparation.

At the Awards Luncheon CERTIFIED MEDICAL ASSISTANT Awards were presented to Martha King and Linda Nance of Tupelo and to Venita Hughes and Darlyn Isely of Gulfport. Marilyn Peterson of Gulfport added her clinical specialty to her previously earned CMA and Deborah McAllister of New Albany received her CMA-C. Dr. William T. Oakes of Amory was re-elected to serve a three year term as National Advisor.

Following a week of educational and social events, AAMA President-Elect Wini A. Schwartz, CMA-AC, Los Angeles, was installed as president.

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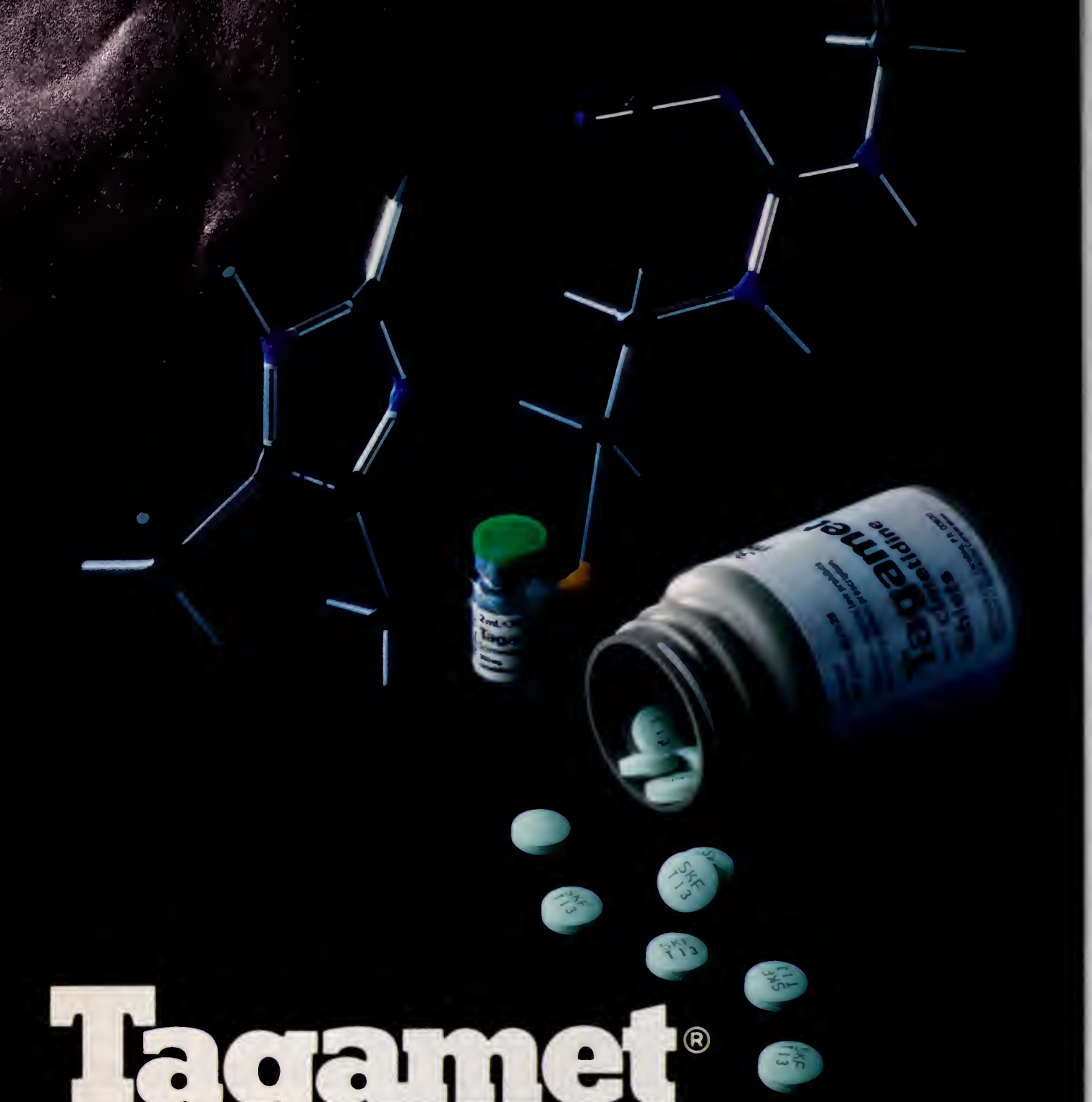
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ERRATUM

The title of the lead scientific article in the November issue (page 201) of Journal MSMA contained an error; it should have read "Amyotrophic Lateral Sclerosis in Kansas." — The editors.

Voluntary Effort Receives Praise

The American Medical Association, American Hospital Association and American Federation of Hospitals' "Voluntary Effort" to restrain hospital costs has received support from two high Carter Administration officials. During a meeting of the National Steering Committee on Voluntary Cost Containment in Washington, D. C., Barry Bosworth, chairman of the Council on Wage and Price Stability, and Robert Strauss, special counsel to the president, said that President Carter "wanted us to come here today to encourage you in your efforts to contain health care costs." Although the Administration failed to obtain enactment of hospital cost containment legislation, Strauss said the Administration recognizes the significant progress of voluntary programs in the fight against inflation.

Bosworth said both he and Strauss were "eager to work with the VE on a cooperative basis." Hospitals are "one of the very few industries in which deceleration (of the rate of inflation) has succeeded," Bosworth said, "and this is significant considering the rate of inflation in the rest of the economy." He added that "the design of the Voluntary Effort addresses the unique problems of its own field better than any other industry the Council on Wage and Price Stability has seen."

Following the steering committee meeting, Paul Earle, executive director of the VE, announced at a press conference that the rate of growth in hospital expenditures during the first seven months of the year was 12.8 per cent — the lowest rate since 1974. "The decrease in the rate of increase in hospital expenditures by 2.8 per cent (from 1977) indicates a trend which shows that the VE goal of a two per cent reduction will definitely be accomplished this year," Earle said.

Practice Management Workshop Scheduled

The Medical Association of Georgia, in cooperation with the AMA, will present a workshop for residents, "Starting Your Practice," Jan. 31-Feb. 1, 1979, at Ramada Inn Central, Interstate 85 North at Monroe Drive, in Atlanta.

Faculty will be from the Department of Practice Management, American Medical Association.

Registration fee is $65 for members of a medical society, and $100 for non-members. Spouses may audit at no charge (except $9 luncheon fee). Enrollment is limited to first 25 registrants.

Contact Sue McAvoy, Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta, GA 30309. 404-876-7535, 800-282-0224 (toll free), for more information.

This workshop is designed for young physicians planning to enter private practice and covers:

—financial controls and bookkeeping systems, billing and collection, medical records and filing, insurance processing.
—appointment scheduling, patient information booklets, systematizing the telephone, staff training.
—recruiting, hiring job description, personnel policies and communication, training, evaluation, supervision, delegation — what, how and when.
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DATELINE

Accident Victims Need Routing Systems

Chicago, IL - Accident victims are dying unnecessarily because many communities have not yet established routing systems to ensure that the injured are transported to hospitals that are staffed and equipped to handle them. In the JAMA report of a study by a nationwide group of surgeons, they state, "There is little question that hospitals having extensive experience with injured patients offer better care than hospitals receiving only an occasional trauma patient."

High Heeled Shoes Cause Foot Problems

Dallas, TX - As the heels on women's shoes rise, so does the incidence of foot problems, warns the University of Texas Southwestern Medical School Department of Orthopedic Surgery. They say that foot deformities and pain caused by improper shoes are significant public health problems and as a result of the irrational shoes they wear, women undergo 40 times more bunion surgery than men. Preventive measures include wearing shoes wider in the toe and lower in the heel.

College of Surgeons Publishes Factbook

Chicago, IL - To meet continuing demand for socioeconomic data relating to surgery, American College of Surgeons has published Socio-Economic Factbook for Surgery. Some highlights from the fact book are: From 1949-50 to 1976-77, total number of medical students increased 132%. In 1969-70, surgical residents comprised 40% of all residency positions, while in 1976-77 they were 31%. Percentage of residents in primary care specialties increased from 26% to 42%.

Needs of Older Women Are Studied

Bethesda, MD - Women in the 65 and older age group are the fastest growing segment of the U.S. population, with 13.9 million older women (versus 9.5 million older men) in 1977 expected to increase to 33.4 million women (versus 22.4 million men) by the year 2035, according to the HEW National Institutes of Health. Women are also living much longer than men. The National Institute on Aging and National Institute on Mental Health are now studying the needs of this age group.

Med Society Sets Cigarette Policy

Philadelphia, PA - Pennsylvania Medical Society's Board of Trustees adopted a policy statement on cigarette use. The statement "recognizes the role of smoking as a public health hazard...and actively encourages...patient education efforts designed to minimize health risks attributed to smoking." It calls on physicians to establish personal health patterns which result in healthy living and to assist their patients to stop smoking by example and supportive encouragement.

Neurology Meeting Planned for Fort Lauderdale

The Southern Clinical Neurological Society announces its sixth annual meeting to be held at Pier 66 Hotel, Fort Lauderdale, FL, Jan. 22-26, 1979. Program Chairman is Dr. William L. Griggs, Holt-Krock Clinic, 1500 Dodson Avenue, Fort Smith, AR. The meeting will present "Recent Advances in Neurology."

Further information about the meeting can be obtained from Dr. B. J. Wilder, Secretary, University of Florida Hospital, Gainesville, FL.

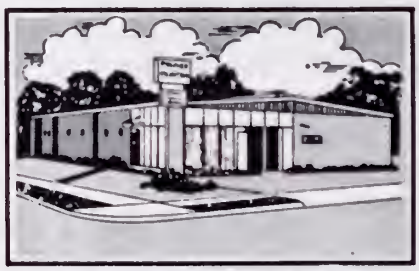
Hair Transplant Symposium Is Set

The annual hair transplant symposium and workshop will be held in Hot Springs, AR, Jan. 25-27, 1979. It is sponsored by the American Academy of Facial Plastic and Reconstructive Surgery, Inc., and endorsed by the American Society for Dermatologic Surgery.

Registration fee is $720. For further information, contact Dr. D. B. Stough, III, program director, Doctors Park, Hot Springs, AR 71901.

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UMC Establishes Division of Psychology

A Division of Psychology has been established within the Department of Psychiatry in the School of Medicine at the University of Mississippi Medical Center. Dr. William G. Johnson, associate professor of psychiatry (psychology) is the new division chief.

UMC Vice-chancellor Dr. Norman C. Nelson announced the creation of the division and Dr. Johnson's appointment following approval of the Board of Trustees, Institutions of Higher Learning.

Dr. Johnson will direct a faculty of five full-time and seven part-time clinical psychologists.

UMC Graduate Student Demonstrates Herpes Enzyme

A University of Mississippi Medical Center graduate student has received the McClesky Award from the South Central Branch of the American Society for Microbiology for his demonstration of an enzyme present in most types of herpes viruses.

John McGowan, a graduate student in the UMC microbiology department, is the first person to describe the presence of the enzyme.

The annual award, a certificate and cash prize, goes to the graduate student who presents the best paper at the society's annual scientific assembly. McGowan was competing with graduate students throughout the three-state region.

With the grant support from the American Cancer Society, Dr. Glenn Gentry, professor of microbiology and acting chairman of the department, conducts and directs research into a compound (araT) believed to be effective in halting the growth of the herpes viruses.

Previous work at the Medical Center suggested that araT's effectiveness might stem from its ability to interfere with the virus's reproductive machinery centered around a viral enzyme.

Despite published works elsewhere which stated that the viral enzyme did not exist, McGowan's laboratory studies proved its presence conclusively, according to Dr. Gentry.

By purifying both the viral enzyme, deoxythymidine kinase, and cellular enzymes, McGowan has shown that araT reacts with the viral enzyme, but with nothing else.

"One of the big problems in anti-viral research is finding a compound which halts virus growth but leaves healthy cell tissue intact," McGowan said. "AraT appears to be such a compound."

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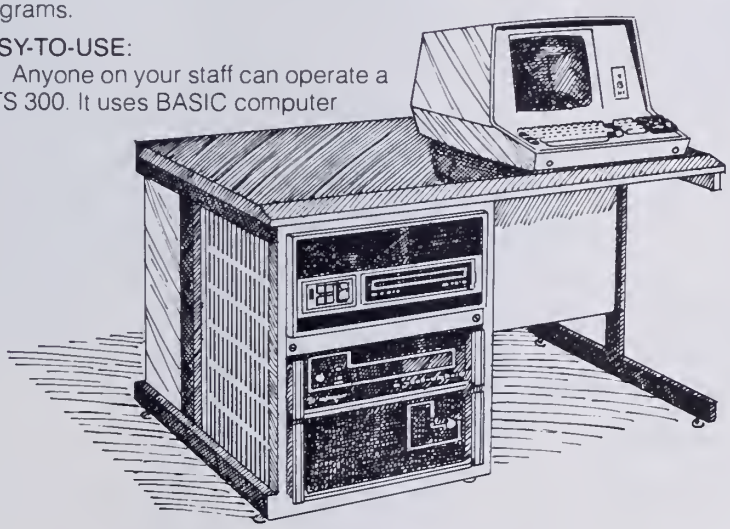
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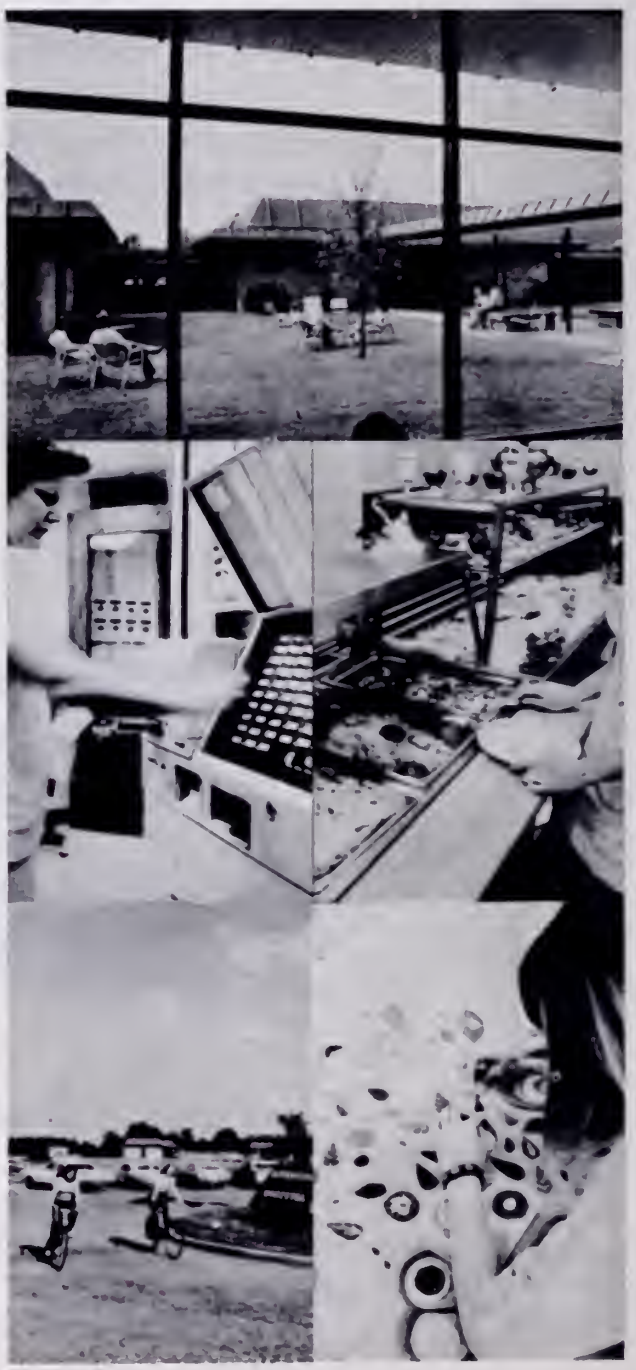
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JOURNAL OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION
December 1978, Vol. XIX, No. 12

ORIGINAL PAPERS

Tubular Hindgut Colonic Duplication: Report of a Case

J. PRESTON HUGHES, M.D., and
JOHN E. RAY, M.D.
New Orleans, Louisiana

A case is presented illustrating the rare anomaly, tubular duplication of the distal colon. When a low blind pouch is present, distal transanal septotomy of the blind pouch may be the treatment of choice.

OUR INTEREST in rare duplications of the colon was kindled by a 15-year-old boy with recurrent urinary tract infection. His presenting symptoms were explained when a rectourethral fistula was demonstrated on cystogram. We discovered the colonic duplication when a diverting transverse colostomy was performed before repair of the fistula. Perineal septotomy of the duplicated pouch is the simplest and most effective treatment. This manages the problem of draining the obstructed duplicate segment, and complements the proximal communication by distal drainage.

Case Report

A male infant was treated elsewhere in 1960 for abdominal pain, abdominal mass, and prolapsing rectal mucosa. Intravenous pyelogram demonstrated bladder displacement to the left. A barium roentgenogram of the colon failed to demonstrate a duplication. The patient had a rectal operation in 1960 for the "prolapsed rectal mucosa." His abdominal mass, painful defecation, and tenderness resolved; however, the patient continued to be plagued with recurrent urinary tract infections and bouts of "epididymitis." When he was six years old, he had a right orchiectomy, but continued to have recurrent urinary tract infections for the next several years.

In December 1973, he was admitted to Ochsner Foundation Hospital and the diagnosis of rectourethral fistula was established by a contrast cystogram. The contrast material extravasated into the rectum from the proximal urethra.

A transverse colostomy was performed in preparation for the fistula repair, and we were surprised to find that the colon had two lumens (see Figure 1). Subsequent barium colonic x-ray films demonstrated duplication of the colon distal to the colostomy (see Figure 2). Postoperative proctosigmoidoscopy demonstrated a septum in the proximal rectum. The rectourethral fistula was repaired in March 1974 through a perineal approach. The prostate epithelium was excised from the proximal urethra and the rectotomy and urethrotomy were closed. A suprapubic catheter was placed in the bladder. The colostomy was closed in July 1974, preserving the septum and two lumens.

There have been no recurrent urinary tract infections. Postoperative barium colonic roentgenogram demonstrated duplication to the proximal transverse colon (see Figure 3).

From the Department of Colon and Rectal Surgery, Ochsner Medical Institutions, New Orleans, LA.
Presented at the meeting of the American Society of Colon and Rectal Surgeons, San Diego, CA, June 12-15, 1978.
Present address of Dr. Hughes, 2200 East 4500 South, Salt Lake City, UT 84117.



Figure 1. Colonic duplication demonstrated by the four lumens encountered during a diversionary transverse colostomy.



Figure 2. The double lumened distal colon from the area of the divided colostomy to the proximal rectum.

Discussion

Colonic duplication is established by three criteria:[1] (1) a lining of alimentary epithelium, (2) smooth muscle in the wall, and (3) attachment to some portion of the gastrointestinal tract. The criteria are further limited by Soper:[2] (1) no other gastrointestinal duplications, (2) the tubular form is different from the cystic or spherical duplication forms, (3) connection with the parent colon, generally proximally, (4) no ectopic mucosa, (5) located on the antimesenteric rather than the mesenteric side, (6) theories of intestinal duplication elsewhere do not hold, and (7) high association with duplications of the genitourinary system.

The embryologic explanations of colonic duplication are confusing. The two encompassing theories are hindgut twinning and defective development. The former theory is that the primitive intestinal tube forms a supernumerary structure,[3] and the latter, that duplication occurs during embryonic vacuolization and coalescence of the primitive gut lumen. A small vacuole is "pinched off" and forms a duplication cyst or lumen.

The presenting symptoms of colonic duplications usually are the result of complications such as obstruction, perforation, hemorrhage, or pain.[4] An abdominal mass often may be palpated (as it was in our patient), or tubular duplications may be asymptomatic and discovered by chance.[4] If there is proximal colonic communication only, the blind pouch results in a large, tubular mass. Our patient's operation during infancy probably divided the prolapsing blind pouch which allowed distal drainage (distal septotomy). The mass was decompressed and the pain was alleviated. The patient's subsequent recurrent urinary tract infections were due either to iatrogenic or congenital rectourethral fistula.

The colonic duplication was no problem except when encountered during the diversionary colostomy. The colostomy was sutured to the subcuticular skin incision. The mucosal septal separation was left



Figure 3. Colonic duplication distally forming a normal rectum to evacuate both colons.

as an end on the proximal and distal colostomy. When the colostomy was closed, we reanastomosed the mucosal septum as well as the anterior and posterior portions of the colon. The postoperative bowel function was normal, and postoperative barium studies illustrated duplication to the right colon which was normal. When a low blind pouch is present, distal transanal septotomy of the blind side may be the treatment of choice. ★★★

Dr. Ray — 1514 Jefferson Highway (70121)

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To Dr. Ferris

These people choose to live a life
Healing people through their strife.
Noble men, golf clubs in hand,
But, oh, the work to join this clan!

First comes college with its blows
With no time for either girls or beaux.
Then comes the fighting to enter trauma,
Entered then starts the Med School drama.

Next you're up there on that stage,
Graduating at such an ancient age.
You're 26 and starting more schooling,
The work's just started, endless, grueling.

Struggling intern of 28 years,
And still you're training along with your peers.
Residency next, you're 30 now,
You're finally through, so take a bow!

But wait, now come the riches you sought
For which the grades you daily fought.
But you were foolish to believe so,
You're married now and have a family to tow.

Finally you're settled, ready to enjoy.
Think again, now you're in the government's employ!

Written by:
CLAIR ROACH

Editor's note: Dr. Lucian Ferris of the Street Clinic in Vicksburg recently received this poem from his 15-year-old patient. The editors felt the MSMA members would enjoy the poem.

111th Annual Session of MSMA

May 6-10, 1979

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B. FRANK VOGEL, M.D.
Hattiesburg, Mississippi

"Grow old along with me!
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The last of life, for which
the first was made."
—ROBERT BROWNING

TREMENDOUS advances in medical care and health education have resulted in the emergence of a new type of older person, who is gradually or perhaps radically altering our image of old age. The decline of the death rate in infancy and earlier years means that more people live to grow old — to reach and surpass the scriptural "three score and ten" years of age. We are discovering a tremendous reservoir of better educated, vitally alive, and vigorously alert people in their seventies, who are intact, capable and unregressed.

All people grow old — and they share certain basic anchorages through life. If these are good, firm, and lasting, they are lifelong protections against the inevitable hurts and losses of living. They are:

a) an intact body and body image: If there is a sense of basic body security and an acceptable body image, our capacity to bear anxiety and stress later in life is increased.

b) An acceptable home: From the security of an intact home and the security gained from a full family, we derive those facets of personality related to trust, tenderness, self-control and independence.

c) a socioeconomic anchorage: This is based on and reached through the preceding phases, plus new identifications, which include friendships, and other relationships in which trust, faith, constancy, responsibility, and the like are lived through and experienced in school, the military, and work situations.

d) a meaningful identity and purpose to life: This can be as varied as life itself, and may be found in one's family, in science, art, literature, work, religion or other constructive, socially approved activities, that give life its purpose and zest.

Medical Director, Pine Belt Regional Mental Health and Retardation Complex, Hattiesburg, MS.

For each person, life has been a continuous process, with one normal or abnormal crisis following another. At each critical point of growth and stress, there are several paths a person can take:

1) he may cope relatively easily, mastering and integrating the stress and actually growing thereby;

2) he may be incapable of dealing with the crisis and find himself deeply engaged in a lasting conflict, marked by anxiety and regressive traits;

3) he may complain unendingly about his bad luck and unhappy fate, and make each life event a source of anxiety and repetitive tragedy. Such a person has had a need for punishment unconsciously, long before any life crisis occurred. In such people, aging represents a continuation and exaggeration of their special and unhappy interpretations of life.

Because of the extraordinary diminution of infant and child mortality, great numbers of people are now reaching the age of 65 and beyond. Twenty-two million, it is estimated in this country, are 65 and over. The quality of life is increasingly important for this group. Mental health information and management are becoming essential in the daily practice of every physician, be he family practitioner or specialist.

Healthy Old Age

A study of persons enjoying a happy and healthy old age reported that this was based on homeostasis — continued stability in every area of functioning. Disturbances of homeostasis can occur and do occur in many ways. Physiologic changes in the body occur in response to unexpected happenings and the body prepares for immediate action. When the crisis is over, the previous balance is restored. If this does not happen, the changes tend to persist and the final stabilization is on a lower level and this is termed regression.

These are aging people who involve themselves in situations which they cannot handle alone, or who

make major frustrations out of minor incidents. Such people are in a constant state of excitement within, as if they were mobilized for a battle. Others, on the contrary, are so afraid to attempt any new action to deal with unexpected events, that their normal capacities for adaptation become rusted and atrophied from disuse.

In a study of centenarians, those who had aged successfully and happily had shown ingenuity in avoiding frustration. They had escaped conflict with authority. They had built small businesses and had not been enmeshed in a ladder-climbing race with competitors. They had worked hard, but had set themselves only reasonable goals which they reached. They were sociable, had many interests, were active and did not worry over minor annoyances. Because they had taken reasonably good care of themselves, they had avoided acute illnesses almost completely. They had taken unhappy inevitable occurrences in their stride, and seemed not to have reacted to personal injury with more than temporary symptoms of anxiety and depression. In this group, most had been married and the marriages had been good ones. If the spouses died, they married again. They were all religious but they avoided the extreme of orthodoxy and were not bigoted. They were more interested in being active and productive than in being perfect. They remained interested in new ideas, and continued to be curious and inquiring in their attitudes.

Helpful homeostasis during the senium depends on learning to use one's available energy and time. It involves the development of more effective patterns of response to anxiety and stress which, in turn, decrease susceptibility to illness in ways that almost suggest immunity.

The wise and humane physician will discuss retirement plans with his patients who are reaching their middle years. These should include hobbies and interests that are year-round and varied. One can get mightily bored with a steady diet of reading or of fishing. The possibility of a hobby becoming a part-time job can be explored, and membership in retirement organizations recommended. Many corporations are presenting their 50-year-old employees with subscriptions to such organizations and clubs. Referral to Mental Health Centers for avocational counseling is another helpful measure. Physicians can also profit from the good advice they give others. ★★★

102 Lynnwood Circle (39401)

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Radiologic Seminar CLXXXVII: The T.I.A. Pitfall

ALLEN R. YATES, M.D., and
DOUGLAS R. STRINGER, M.D.
Jackson, Mississippi

WITH THE increasing number of referrals for evaluation of "transient ischemic attacks" a periodic reminder is helpful to emphasize that intracranial pathology frequently mimics the TIA syndrome or may present coincidentally with neck vessel disease.

Case Report

The case illustrated here is that of a 66-year-old male with a 2 to 3 month history of intermittent difficulty with speech and vision. Arteriography not only demonstrated severe plaque stenosis of the left internal carotid artery in the neck, but also revealed a mass effect in the right temporal lobe. Subsequent CT scanning confirmed a multiloculated enhancing neoplastic mass which on biopsy proved to be glioblastoma multiforme.

The surgeon's careful history and neurological exam will usually arouse suspicion which dictates more intensive search for other disease. But when clinical exam is unrevealing, arteriography often will be the only neuroradiological procedure performed, and it behooves the radiologist to strive for a technically superior selective catheter study with full arterial and venous phase filming in both frontal and lateral projections — in addition to the various films

Sponsored by the Mississippi Radiological Society.
From the Department of Radiology, Mississippi Baptist Medical Center, Jackson, MS.



Figure 1. Lateral film of left common carotid injection shows severe plaque stenosis of the takeoff of the internal carotid artery in the neck.



Figure 2. Lateral film of the right carotid injection in this same patient reveals a temporal lobe mass effect.

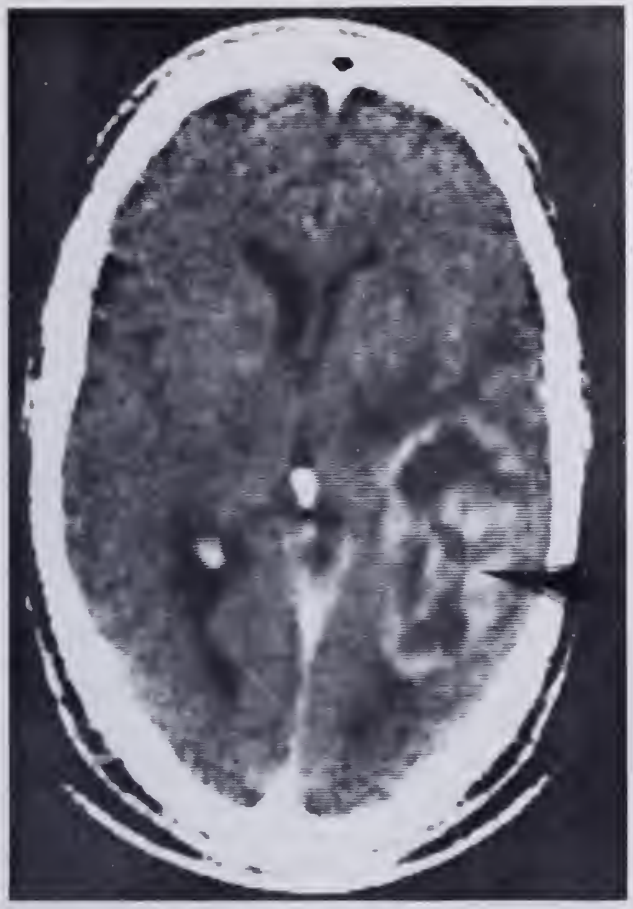


Figure 3. CT scan demonstrates the enhancing neoplastic right temporal mass.

of the neck and arch vessels. Failure to give proper attention to the intracranial study because of preoccupation with the neck vessels may allow an unsuspected intracranial lesion to escape detection on this initial study.

In summary, careful history and neurological exam and good quality cerebral arteriography are essential in the evaluation of all TIA's to avoid missing intracranial pathology. ★★★

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Which is Hope
The heart of Christmas
Which is Love.

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Special Article

(Editor's Note: The following article, first of a three-part series concerning health planning in Mississippi, is reprinted with permission of The Sun-Herald, *Biloxi-Gulfport, published Oct. 15, 1978.)*

Finch Atop Health Planning Pyramid

By EDITH BIERHORST BACK
***Sun-Herald* Staff Writer**

The federal Health Planning and Development Act, in effect since January 1975, was designed to hold down the costs of medical care while assuring that all citizens have access to good care.

In Mississippi, health planning has not succeeded in reaching these goals. A number of sources cited the primary reason as political control by the governor's office.

There are two health planning agencies in this state: the Mississippi Health Systems Agency (MHSA) with its 10 subarea councils, and the Mississippi Health Planning and Development Agency (MHPDA). The former is a private, nonprofit corporation, the latter a state agency under the governor's office. (As a private entity, the MHSA is not bound by civil service salary limits. MHSA pays a planner $26,000 a year, while MHPDA pays $17,000.) Both are supported by grants from the Department of Health, Education and Welfare, MHSA with $1.047 million, and MHPDA with $428,000 this year.

While Mississippi qualifies for four HSAs, Finch chose to have a single HSA to cover the entire state, a decision a number of persons claim was made to allow the governor to control its final decisions.

'Governor Can Do anything'

"With one HSA, the governor can do anything," said Fred St. Clair, the recently ousted Commissioner of Public Welfare who prepared initial MHSA plans for Finch. St. Clair, however, recommended four HSAs. "The governor made the decision to have one," he said, and never responded to a memorandum he wrote urging multiple HSAs to guarantee "grass roots" control over health planning. "I was upset," St. Clair added.

The decision was made after Finch took office in January 1976, but planning for the state's agency preceded him. Gov. Bill Waller, who had also advocated one HSA, was promoting the Mississippi Health Improvement Agency which represented the state's medical association and hospital interests, then operating the Regional Medical Program with federal grants for medical research and demonstration projects. The new health planning law eliminated the RMPs but in its phaseout year, RMP had funds to distribute to those wishing to prepare HSA applications.

"They had $40,000 for all applicants to use, but they gave it all to themselves," St. Clair said.

The Mississippi State Medical Association, which had recommended a single HSA — the MHIA — in 1975-76, today is calling for more. Last year, the society's president, Dr. James O. Gilmore, deploring health planning as "a political football game," and "too centralized," called for "three or four HSAs" for the state. The new president, Dr. Carl Evers, speaking for the association, said last week that he is in agreement with Gilmore since "the governor's office controls it (MHSA) entirely."

In 1976, with Waller out, the physician-supported MHIA lost its major supporter, and Finch, with the aid of St. Clair and his campaign manager, Dr. Howard Clark (who, according to St. Clair, had split with his medical colleagues over the issue) supported the competing MHSA.

Nursing Homes Aid Finch

Aiding Finch in getting control of health planning away from physician and hospital interests was the state's nursing home interests, powerful since "a number of state senators own nursing homes," St. Clair said. "The hospital association and medical society were on the opposite side in the governor's race," and later in Finch's "conflict over the Board of Health (the society claimed it should select its head)." There were "many supporters of Finch from the nursing home association, especially certain factions," St. Clair said. "James Myrick owns a number of planes and the governor used one in his campaigns." Myrick, owner of three nursing homes, acknowledged he loaned Finch a plane, but declined further comment.

MHSA's predecessor, the Governor's Division of Comprehensive Health Planning, with similar tasks of reviewing capital expenditures "tended to approve everything that came to them," said Dr. James B. Moore, coordinator of planning of MHPDA. One of its last actions was the approval of $7.6 million worth of hospital expansion and $4 million of nursing homes. Since replaced by MHSA, hospital expansion has ceased while nursing homes still grow.

Plans for capital expenditures of $100,000 or more are first sent to the subarea council of MHSA, whose board members are elected in their regions.

"Originally the elections were conducted in an open manner," St. Clair said. "I'm proud of them. But now people have become sophisticated. There are trade-offs. The public is not as interested as they were. It's easier now for factions to control." He attributes this to public dissatisfaction about "few council recommendations taken by the HSA. If there had been four HSAs from the beginning, with boards locally elected without state input, the general public would participate."

From the subarea councils, applications go to the MHSA, whose 34-person board is selected with 27 recommendations to the governor from the councils, and 7 additional direct appointments by the governor.

From the MHSA, the application moves up to the MHPDA, whose board, the State Health Coordinating Council (SHCC) consists entirely of 27 Finch appointees. MHPDA submits the final recommendation of HEW on whether or not to issue a federal certificate of need which entitles the applicant to receive Medicare and Medicaid at a rate which includes capital costs. If MHPDA rejects, the applicant has the right to a fair hearing, conducted by a fair hearing officer appointed by Finch.

While the health planning agencies' decisions must be justified by the state plan, those of the hearing officers may not. The power of the officer to circumvent the plan by approving unneeded facilities rejected by the agencies, was revealed in hearings before the Senate Subcommittee on Health and Scientific Research of the Committee on Human Resources last February.

"Federal reimbursement will be provided for the construction of three unneeded nursing homes in Mississippi," HEW's Under Secretary Hale Champion told the subcommittee. "The fair hearing officer intentionally allowed the review period to expire. This state hearing officer was removed from future participation in the section 1122 appeals process due to these actions."

Frances Dearman, public information officer in HEW's health planning unit, identified the officer cited by the Under Secretary as Jackson attorney Marshall Lusk, the homes Zion Grove, Rest Haven, and Mound Bayou Nursing Homes.

"The regional administrator in Atlanta contacted the governor's office and asked that that officer not hear any more of these matters," Ms. Dearman said. "He was not pleased with the actions." Attempts to reach Lusk for comment were unsuccessful.

Governor Has Final Say

Glenn Goodwin, who resigned as MHSA director last April, was asked to confirm a statement attributed to him that it does not matter what happens in review committees since it is the governor who decides who receives a certificate of need.

"That is essentially correct," he said. "The HSA reviews and makes a recommendation to the state agency which is in the office of the governor, and they're the only ones that can say yes or no. The governor has the final say in his office. If (an applicant) gets negative comments and accepts the offer of a fair hearing, the governor appoints the officer. He does have final say because it comes to his office or to his fair hearing officer."

Finch also gives to the MHSA, the nongovernmental agency, his recommendations for top officer. Last February Finch wrote to MHSA board president, Dr. Howard Clark, that he recommended Dr. William O. Barnett be elected president for the coming year. At their Feb. 23 meeting, Barnett was elected by acclamation.

The original SHCC also included Senators Nap Cassibry and Theodore Smith. Cassibry served until last spring. Smith resigned in mid-1977.

"I am forced to conclude that these organizations are primarily being operated on the basis of political considerations," Smith wrote Finch in his letter of resignation.

In a May 1977 letter to Clark, then MHSA president, but also on the SHCC, Smith complained of the political maneuvers that blocked multiple HSAs.

Charges of Committee Tampering

"Several weeks ago the president of the State Health Coordinating Council, Mr. Fred St. Clair, appointed an ad hoc committee to study the matter. After careful consideration the members of the ad hoc committee voted unanimously to recommend to the Governor four health systems agencies," Smith wrote. "It seems apparent that someone had a desire that the committee refuse to make this recommendation and two additional members were added to the Plan and Development Committee. After these additions the committee voted 4 to 3 for a single state agency. Had the committee membership not been tampered with, it would have unquestionably voted for multiple health systems agencies for the state."

The additions to the committee were Lester R. Howell, Governor's Office of Planning, and Latrelle Ashley who had served as field coordinator for the governor's campaign. (Ashley is still a SHCC member.)

St. Clair, asked last week to comment on Smith's letter, said, "That's exactly what happened. The governor did, through Dr. Clark, mention to me that there were two vacancies on SHCC and when appointed, they had to go to that committee. I had been told that he and Dr. Clark had decided, for political reasons, that he would have only one."

"In a recent telephone interview," Smith said, "They did that all the time. If they learned they would lose a vote, they would shift the membership. Clark and others would delete or add to carry votes as they wanted. They had the authority, or usurped it, to do what they wanted."

Until now, the legislature has not been involved with the health planning agencies, established by executive order. Last August the MHSA received its "full designation" from HEW, MHPDA cannot until the state passes a certificate of need law.

Two state senators, Cassibry and Smith, are preparing bills to present at the next session. While the two are similar, designed to meet federal guidelines, there is one essential difference. Both would combine the MHPDA, the Commission on Hospital Care, and the licensure and certification division of the Board of Health. Cassibry's bill, however, creates a 7-person Mississippi Health Care Commission, five members of which are appointed by the governor, the others the chairmen of the Senate Public Health Committee and the House Committee on Pensions and Social Welfare. Smith's version would incorporate the various functions in the Board of Health.

Difference in bills: Who Is Boss?

"The only difference is who is to be boss," Smith said. "Under Cassibry's bill, the governor would be appointing a number of members. And I don't think legislators should serve on executive boards and we shouldn't create another agency." MHSA's associate director, Paul Brown, supporting the Cassibry version, said, "There's a question in my mind about putting it in the board of health. That's a state agency which is both a purchaser and a provider of medical care. Should it also be the planner of those services?"

Some of the most severe critics of the state's health planning network still believe that "health planning can work if we can get it out of politics," as Russell Swansburg, Moss Point nursing educator put it. Smith and St. Clair said essentially the same thing. But all pointed to the special interest politics that hinders the development of services which would assure health care to everyone while containing costs.

The Mississippi Lung Association suggests that Mississippians who smoke should consider "Kicking the Habit" and become nonsmokers before the holiday season is over. The "Gift of Quitting" would be a Christmas gift to cherish for "life and breath." Others may wish to make a New Year's Resolution to quit smoking and for those who achieve the status of nonsmoker and want to proclaim their success, the Mississippi Lung Association has free "I Quit Smoking — Just for the Health of It" lapel pins. Contact the Mississippi Lung Association, P.O. Box 9865, Jackson, MS 39206 (phone 362-5453).

Mississippi State Medical Association Auxiliary

The President's Report

MRS. G. SAMUEL ROWLETT, JR.
Vicksburg, Mississippi

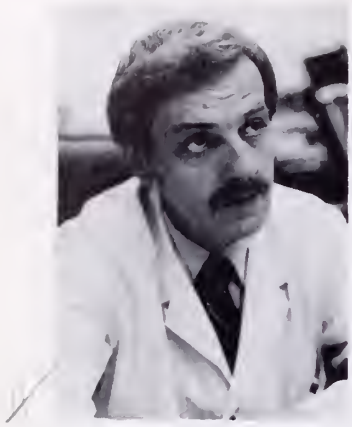
The Mississippi State Medical Association Auxiliary members are presently in the process of contacting their local state senators and representatives to extend them a personal invitation to attend a luncheon at the Coliseum Ramada Inn in Jackson on Jan. 16, 1979. This luncheon will be in conjunction with the State Auxiliary Board meeting, the theme of which is "A Day with the Legislature." We plan to visit our state Capitol and acquaint ourselves with the way in which our legislature works, meet elected officials from the entire state, and let them know we are concerned and interested in their duties. We can become politically educated and effective by learning ways in which medical families can be of service to our state. The featured speaker for the program will be Dr. Carl G. Evers, president of the Mississippi State Medical Association.

We *did* make a difference at the legislative session in January of 1978! We are pleased to report that the optometry bill was killed in committee and we feel that we contributed substantially to its defeat. Bills dealing with laetrile, optometry, and chiropractic still remain primary concerns. We must continue to practice defensive politics to insure the availability of top quality health care for all people in our state. We in the United States are fortunate to be provided the world's finest medical care. As informed members of the medical community, it is our responsibility to work ever ceasingly to keep the persons entrusted with making our health care laws informed of what we consider will be helpful or harmful to citizens of the state and nation.

The Auxiliary continues to be a potentially powerful lobbying group, as evidenced by our representation last January. As medical spouses, we have an obligation to remain involved in all legislative activities in which our busy physicians cannot take time from their practices to participate.

In January of each year, the MSMAA designates one day to become familiar with the workings of the Mississippi legislature, including a visit to the capitol building and an opportunity to meet our governor and other state officials. We hope to learn firsthand how bills are made and passed. Our local and state medical auxiliaries are more than ever aware of the need for those in the medical profession to continue to be politically active.

It is important to remember that next summer an election will be held to choose new legislators and state officials. Come to our January board meeting and meet these lawmakers and hear Dr. Evers speak on subjects concerning the position being taken by the Mississippi State Medical Association on forthcoming legislation dealing with matters affecting the medical profession. Auxiliary members won't want to miss this opportunity to become informed, educated, and armed with invaluable information to be used in future lobbying endeavors to help insure better health care programs for residents of our state. ★★★



The President Speaking

Medical Care Costs—A Public Concern

CARL G. EVERS, M.D.
Jackson, Mississippi

INCREASING medical care costs have become the "Achilles heel" of our present system of medical care in this country. What we as physicians do (or don't do) to control these increasing costs will be decisive in deciding the future of the system.

We can point to a number of logical reasons for today's medical care costs. Expensive new technology, increasing demand for health services stimulated by so-called "free" medical care programs such as Medicare and Medicaid and the hedonistic habits of the American people reflected in mortality statistics for cancer, heart disease and accidents are a few reasons.

But the fact remains that medical care costs are increasing faster than the general rate of inflation, which everyone agrees is out of control, and we as physicians, although only receiving some 20 per cent of the medical care dollar, are responsible for ordering some 70 per cent of medical care expenditures.

The AMA recently published a "Physicians' Cost Containment Checklist" which I hope each physician and his office staff will read when it arrives in this month's MSMA "Blue Sheet." The "checklist" contains many constructive suggestions that can be employed in our practices to help reduce medical care costs.

Let there be no doubt as to the recourse the public has, for better or worse, if we do not project our concern and efforts to control rising medical care costs. The history of public regulatory mechanisms in this country indicates that they have been put in place only after all else failed, beginning with the failure of the regulated to address public concerns.

Medical care costs have become a public concern. Mandatory hospital cost containment, restructuring of the health care system via some form of National Health Insurance and other forms of medical cost controls can become answers to this public concern based on our inactivity. ★★★

EDITORIALS

JOURNAL OF THE
MISSISSIPPI STATE
MEDICAL ASSOCIATION

VOLUME XIX, Number 12

DECEMBER 1978

Saved by the Bell

As the gavel sounded to end the 95th Congress, many of the Administration's top priority bills were lost in the scramble to adjourn. The Hospital Cost Containment proposal dropped by the wayside, as did the Child Health Assurance Program (CHAP). This latter would have extended Medicaid to children of poor families and to pregnant women, and was high on the government's list of proposals. Many other minor bills were lost in the shuffle. These included federal control of clinical laboratories, an overhaul of drug laws, and expansion of Medicare coverage of chiropractors' fees.

The Administration was not the only loser. Two AMA proposals were also lost in the rush. One would have repealed the Social Security Act, Section 227, which placed a limit on reimbursement of teaching physicians, and the other would have amended the PSRO Law to protect PSRO information from disclosure under the Freedom of Information Act.

Among the bills which managed to beat the gong were measures dealing with HMO, nurses' training, appropriations for health services research, and special pay for federal physicians.

Although the "Feds" passed very little major health legislation at this session, the politicians immediately began mapping strategy for the next session. The big push for National Health Insurance (NHI) will continue with serious efforts being made to pass legislation next year.

Organized medicine may have been saved by the bell in this round, but every effort must be made in the future to resist government control of medical freedom.

GEORGE H. MARTIN, M.D.
Associate Editor
Vicksburg, MS

MD's Successful Countersuit Reversed by Appellate Court

An Illinois appellate court has reversed a 1976 trial court decision in which a radiologist won a countersuit against a patient and her attorneys after they filed a medical malpractice suit against him.

In June 1976, the Illinois trial court jury awarded the radiologist $2,000 in compensatory damages and $6,000 in punitive damages. In the patient's malpractice suit, which she withdrew before trial, she alleged that the radiologist had failed to diagnose a fracture in her little finger.

In reversing the trial court's decision, the Illinois appellate court held that the radiologist's complaint failed to state a cause of action, failed to allege special damages, and failed to allege that the malpractice suit was terminated in the radiologist's favor before the countersuit was filed.

The radiologist's complaint was insufficient to state a claim for malicious prosecution against the patient, her husband (an attorney) and her two attorneys, the court said.

Suits for malicious prosecution cannot be maintained in Illinois unless the plaintiff alleges and proves that the plaintiff in the original tort action acted maliciously and without probable cause; that the prior cause terminated in the plaintiff's favor; and that some special injury not necessarily resulting in any and all suits prosecuted to recover for like causes of action was suffered, the court said.

It is clear that in this case neither of the last two elements was pleaded and, even if the complaint were construed to allege that the suit was brought maliciously and without probable cause by the patient, that issue was not submitted to the jury, the court said.

On the subject of special damages, the court said that the first three items of damages claimed by the

radiologist (damage to his professional reputation, mental anguish, and being forced to spend time on the defense) are so patently common to all litigation that no discussion is warranted.

As for the radiologist's claim that he will be required to pay increased insurance premiums, the court said that an increase in insurance premiums is an item necessarily incident to all malpractice cases and not therefore amounting to damages suffered specifically by the radiologist as distinct from other physicians who have been defendants in malpractice suits.

PERSONALS

ROBERT B. BRAHAN has associated with H. GILES and D. RUSSWURM for the practice of internal medicine at the Medical Group of Hattiesburg, P.A., 820 South 28th Avenue in Hattiesburg.

ROBERT L. BUCKLEY, JR., of Columbus has been selected as one of 50 young leaders for participation in the Mississippi Economic Council's Leadership Mississippi Program for October.

THERESA L. R. BUCKLEY has associated with the Gulf Coast Surgical & Diagnostic Center, P.A., for the practice of ophthalmology at 201 Jackson Street in Biloxi and in the Medical Plaza in Ocean Springs.

GEORGE CARMICHAEL of Canton has been named to a second term as chief of the medical staff of Madison General Hospital. A. P. DURFEY, JR., is vice chief and G. ALLEN ROARK is secretary.

JOHN C. CLAY of Meridian has been named Alumnus of the Year for 1978 at East Mississippi Junior College at Scooba.

ERNESTO D. CORDOVA announces the opening of his office for the general practice of medicine and surgery at the former Austin Clinic in Newton.

EDWIN M. DAVIDSON has joined the medical staff of Garden Park Community Hospital in Gulfport for the practice of internal medicine and medical oncology.

CALVIN S. ENNIS, a family practitioner, announces the opening of his office in the North Bay Family Health Center at Popps Ferry Road and Tee Street in North Biloxi.

JUDITH A. FABIAN has associated with the Gulf Coast Surgical & Diagnostic Center, P.A., for the practice of anesthesiology at Medical Plaza, Vancleave Road in Ocean Springs.

CHARLES N. FLOYD of Gulfport announces the relocation of his office to 1202 Broad Avenue.

A collection of rare and significant books related to Mississippi has been established at Ole Miss by his children to honor VERNER S. HOLMES of McComb. The Verner S. Holmes Collection will be a part of the University Library's Mississippi Collections.

WILLIAM JAMES HUBBARD, JR., announces the opening of his office for the practice of general medicine located next to the hospital in Port Gibson.

MICHAEL E. JABALEY of Jackson and UMC received the Robert H. Ivy Society Award for the best scientific paper at the annual meeting of the American Society of Plastic and Reconstructive Surgeons for "Applications of the Karapandzic Principle of Lip Reconstruction Following Excision of Lip Cancer."

BEN B. JOHNSON of Jackson and UMC has been named surgeon general of the General Society of Mayflower Descendants during their triennial meeting this fall in Plymouth, MA. He is a descendant of William Bradford.

C. M. JORDAN has begun the practice of radiology at the Oxford-Lafayette County Hospital in Oxford.

MILAS S. LOVE, III, of Gulfport was honored on October 29 with an appreciation program and reception at the Best Western Inn for the contributions he has made to the coastal community during the 48 years he has lived in Gulfport.

JOHN M. MCRAE of Laurel announces the moving of his office to 1203 Jefferson Street in the Medical Arts Building for practice limited to surgery.

SHELBY W. MITCHELL has assumed the duties of coordinator of medical services at Ellisville State School.

MAL MORGAN of Natchez has been elected chief of staff of Natchez Community Hospital. JOHN YOUNG was elected vice chief and DAVID BALL is secretary.

MARIO PINEDA of Jackson has been selected to represent Mississippi at the national meeting of the Biofeedback Society of America to be held in San Diego.

WALLACE A. RALLING, a general surgeon, and JOHN B. RUSSELL, a family practice specialist, have set up practice in the former Rayburn medical offices on West Marion in Pontotoc. They will be the first occupants of the new Medical Arts Building next to the hospital on South Main.

E. DAVID RISCH has associated with M. F. LONGNECKER, JR., HAL D. BISHOP, and JOHN P. MORSE for the practice of orthopedic surgery at the Coastal Medical Center in Biloxi.

W. K. Stewart of Pass Christian has been elected chief of Gulfport Memorial Hospital's medical/dental staff. Henry Maggio of Gulfport is vice chief and Leonard Ball of Gulfport is secretary-treasurer.

Perry Trouche of Vicksburg will now see patients on Tuesdays at the Mayersville Health Clinic in Mayersville as part of the National Health Service Corps program.

POSTGRADUATE CALENDAR

Jan. 8-12, 1979
Practice of Electrocardiography
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine and the University Medical Center Division of Continuing Health Professional Education.

Coordinator: Thomas M. Blake, M.D., professor of medicine and chief of the cardiology division and of electrocardiography, University of Mississippi School of Medicine.

Designed for the physician who uses electrocardiograms in his or her daily work, the course will include sessions on mechanism, structure and function. New methods will be discussed with emphasis on computer use. The course is limited to eight participants. Fee: $150.00. Credit: 40 contact hours, .4 CEU, Category I, AMA, AAFP credit applied for.

Jan. 26-27, 1979
Advanced Cardiac Life Support
University Medical Center, Jackson

Sponsored by the University of Mississippi School of Medicine Department of Anesthesiology and the University of Mississippi School of Dentistry Department of Oral and Maxillofacial Surgery, and the University Medical Center Division of Continuing Health Professional Education.

Coordinators: Thomas J. Herrin, M.D., associate professor of anesthesiology, University of Mississippi School of Medicine, and Joseph Nigliazzo, R.N., Department of Oral and Maxillofacial Surgery, University of Mississippi School of Dentistry.

Open to physicians and registered nurses who have been certified by the American Heart Association in basic life support, this course will be taught by faculty qualified by the American Heart Association as advanced cardiac life support instructors. The two-day program is designed for physicians and nurses engaged in advanced cardiac life support on a daily basis. Fee: $100.00. Credit: 12 contact hours, 1.2 CEU, Category I, AMA; AAFP.

Feb. 3-4, 1979
Management: A Key to Successful Medical Practice
University Medical Center, Jackson

Sponsored by the University of Mississippi Medical Center Division of Continuing Health Professional Education.

Coordinator: Roland B. Robertson, M.D., acting director, University Medical Center Division of Continuing Health Professional Education; Assistant Vice Chancellor for VA Affairs; and assistant professor of medicine (part-time).

Management consultants will discuss good private practice management for physicians and their staff in all specialties. Topics will include personnel, finance, records, and group and solo practice. Fee: $100.00 per physician; $25.00 for each staff member. Credit: 12 contact hours, 1.2 CEU, AMA; AAFP.

FUTURE CALENDAR

March 1-3, 1979
Surgical Forum VI
Holiday Inn Downtown, Jackson

March 16-17, 1979
Renal Update
University Medical Center, Jackson

All continuing education correspondence should be addressed to: Continuing Education, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216.

THE LITERATURE

Book Review

God, Man and Medicine, by Charles A. Hoffman, M.D., Parsons, WV: McClain Publishing Co., 1978. 205 pages. $10.00.

God, Man and Medicine is a book worthy of addition to any library, whether private, community

or medical. Written in the language of the layman it serves as an autobiography, a record of historical events and a good source of reference and entertainment. Dr. Carl Hoffman was a distinguished leader and his book vividly and with unusual candor reflects a colorful career, one dedicated to organized medicine, the delivery of top quality medical care to his patients, and a heart filled with gratitude to a benevolent God for his gift of wisdom and his many talents so well portrayed during his lifetime.

His affinity for the truth in his extensive travels, both in the U. S. and foreign countries as he searched for a better system of medical care, can only be surpassed by his deep uncompromising integrity which he so jealously guarded. As he recounts his experiences in medical politics during his ascent to the presidency of the American Medical Association and the many amusing true happenings in the private practice of medicine, one is impressed by the refreshing feeling of common sense, judgement, knowledge and down-to-earth thinking mixed with a dry sense of humor.

The last chapter entitled "Prophecy — The Omega and the Alpha" was particularly touching. Here he reveals his true self as he reminisces — a long and happy journey down life's pathway, filled with memories of duties well performed — a heart filled with love and devotion for his sweetheart of 38 years who had been his inspiration during many trying years — the old riverboat which he enjoyed so much for so long — faith in the God he worships who blessed him with strength, courage and unusual talent.

All so gloriously summarized when he whispers to himself "It has been a good life — God has been good to me."

J. T. Davis, M.D.
Corinth, MS

AMA Issues Book On Medical Practice

The seventh annual edition of the American Medical Association's *Profile of Medical Practice* is off the press, with 283 pages of new information on the economics of medical practice in the United States today.

Most of the information is based on the AMA's Eleventh Periodic Survey of Physicians, in which a cross-section of doctors are asked many questions regarding office finances, working hours and other aspects of medical management.

Among the many new findings of the AMA reference book are —

- Effects of the malpractice crisis of 1975 are still being felt by U. S. physicians and their patients. Almost half of doctors in office practice reported that they have increased their fees to cover rising premiums for malpractice insurance. And more than one-third of the doctors said they are practicing defensive medicine — ordering more tests and procedures to protect themselves against possible legal action.
- Patterns in the geographic location of physicians continue to change, with many of the states in the Northeast and North Central regions of the country experiencing only average or below average rates of growth in physician-population ratios. States which have been traditionally underserved are experiencing more rapid rates of increases in physicians than are states in the balance of the country.
- Since 1975 the rate of increase of physicians' fees, as measured by the consumer price index, has been declining, to 9.2 per cent in 1977.
- For the typical physician, practice expenses increased at a compound rate of growth of 10.4 per cent, 1969-1976, while net income from medical practice increased at a rate of 6.0 per cent over the same period.
- On Dec. 31, 1976, the mean age of male physicians with known addresses was 46.3 years while the mean age of women physicians was 42.4 years. Almost 40 per cent of women physicians were less than 35 years of age.
- The average doctor in office practice worked 47.2 weeks in 1975. The typical physician practiced medicine 52.2 hours per week in 1976, as compared with 51.8 in 1975 and 49.9 hours in 1974.
- The average physician in 1976 was seeing more patients — 128.5 per week — as compared with 126.5 in 1976 and 125.8 in 1974.

Profile of Medical Practice 1978 is a companion book to the AMA's *Socioeconomic Issues of Health 1978*, issued earlier this year. The two books provide health professionals, policy-makers, and researchers with analyses of issues in health care delivery as well as with current health care data.

The editor is John C. Gaffney of the AMA's Center for Health Services Research and Development.

The book is available from Order Department OP-52, American Medical Association, P.O. Box 821, Monroe, WI 53566. Individual copies are $5.00.

1979 MSMA-Robins Award Is Announced

The eighteenth annual Mississippi State Medical Association-Robins Award for outstanding community service by a state physician has been announced to the component medical societies by the Board of Trustees. The 1979 award will be presented at the 111th Annual Session during closing ceremonies on May 10.



MSMA-Robins Award

Dr. Carl G. Evers, president, and Dr. Robert Caldwell, chairman of the Board of Trustees, said that each component medical society has been invited to submit a nomination for the honor. The award is cosponsored annually by the association and the A. H. Robins Company of Richmond, Va., a long-established manufacturer of ethical pharmaceuticals.

Drs. Evers and Caldwell said that nominees must be members of the state medical association and that the community service recognized by the local society's nomination must be apart from purely professional attainment, since suitable awards in this connection already exist.

Generally, the service by the physician-nominee should have benefitted the local or state communities in a civic, cultural or general economic sense. It need not, however, have been a single achievement, since many outstanding citizens contribute to community betterment through a series of services in varying leadership roles.

Nominations should be made by letter, and there are no restrictions upon length or attached exhibits which assist in establishing the nominee's qualifications and record of achievement. Drs. Evers and Caldwell said that each letter of nomination must be signed by an officer of the component medical society. Nominations from previous years may be resubmitted.

Deadline for submission of nominations to the state medical association is Jan. 1, 1979. Each nomination will be acknowledged, and the Board of Judges, consisting of the three MSMA vice presidents, will review the nominations.

The Robins series was instituted in 1962, and the award consists of a sculptured bronze plaque in bas-relief, engraved, and mounted on a mahogany panel.

The 17 Mississippi physicians who have received the high honor are Dr. Thomas G. Ross of Jackson, nominated by the Central Medical Society in 1962; Dr. Frank M. Davis of Corinth, by the Northeast Mississippi Medical Society in 1963; Dr. Howard A. Nelson of Greenwood, by the Delta Medical Society in 1964; and Dr. Maura J. Mitchell of Ellisville, by the South Mississippi Medical Society in 1965.

Dr. J. T. Davis of Corinth, by the Northeast Mississippi Medical Society in 1966; Dr. Frank M. Acree of Greenville, by Delta Medical in 1967; Dr. W. H. Anderson of Booneville by Northeast in 1968; Dr. Omar Simmons of Newton, by the East Mississippi Medical Society in 1969; Dr. W. J. Aycock of Calhoun City, by the Northeast Society in 1970; Dr. Walter H. Rose of Indianola, by Delta Medical in 1971; Dr. Reginald P. White of Meridian, by the East Mississippi Medical Society in 1972; Dr. W. A. Long, Jr., of Jackson, by the Central Medical Society in 1973; Dr. Virginia S. Tolbert of Ruleville, by Delta Medical Society in 1974; Dr. Thomas M. Davis of Jackson by Central Medical Society in 1975; Dr. Thomas G. Barnes of Greenville, by Delta Medical Society in 1976; Dr. Hugh Banks Barnes of Hattiesburg, by South Mississippi Medical Society in 1977; and Dr. Verner S. Holmes of McComb, by South Central in 1978.

Dr. Helen Barnes Appointed to PSRO Advisory Council

Dr. Helen B. Barnes of Jackson has been appointed to a three-year term on the 11-member Professional Standards Review Council of the Health Care Financing Administration. The council is an advisory group to HEW Secretary Joseph Califano, and is responsible for PSRO policy, assessing the progress of the PSRO program, and evaluating the performance of individual PSROs. Dr. Barnes' appointment is effective from August 1978 through June 31, 1981.



Dr. Barnes

Dr. Barnes, an obstetrician-gynecologist, received her medical degree from Howard University in Washington, DC, and completed her ob-gyn internship and residency at Kings County Hospital, Brooklyn, NY.

Acute Radiology Update Scheduled

"Radiology of the Acutely Ill and Injured Patient — Update 1979" is set for Jan. 26-27, 1979, at Stouffer's Hotel, Greenway Plaza, Houston, TX. The course will be presented by the Department of Radiology, The University of Texas Medical School at Houston. Co-sponsor is The University of Texas Health Science Center at Houston, School of Allied Health Sciences and Division of Continuing Education.

Fee is $150.00 and contact the Division of Continuing Education, The University of Texas Health Science Center at Houston, P.O. Box 20367, Houston, TX 77025, (713) 792-4671 for further information.

This course meets the criteria for 14 credit hours in Category I of the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designed. Application has been made to the American College of Emergency Physicians for 14 ACEP Category I credits, and to the American Academy of Family Physicians for 14 prescribed credit hours.

Small Hospitals Safe and Less Costly for Babies

Small rural hospitals can do a first rate job of delivering babies safely, and at less cost than the big city hospitals, research reports in a recent issue of the *Journal of the American Medical Association* indicate.

Federal health planners recently declared that hospitals delivering fewer than 500 infants a year were lacking in quality and efficiency and probably should not be allowed to handle deliveries.

Herman A. Hein, M.D., of University of Iowa Hospitals and Clinics, Iowa City, made a detailed study of the actual results of care in his state in all hospitals, rural and urban.

Because high risk expectant mothers are screened out in advance and sent to specialized urban centers, the small rural hospitals actually have a much lower neonatal death rate than do their big city counterparts, Dr. Hein found. And the average base charges for obstetric services are lower in the small town hospitals than in the cities.

In Iowa, Dr. Hein reports, care is provided for some 42,000 maternity patients per year in 135 hospitals, 82 per cent of which deliver fewer than 500 babies per year. Some 42.5 per cent of all births in Iowa occurred in the small hospitals. The most recent neonatal mortality in these hospitals is considerably less than the statewide rate of nine deaths per 1,000 births, and has been as low as six per 1,000 births in the smallest hospitals for the past two years, he writes.

Most deliveries in small hospitals are attended by family practitioners, rather than specialists in obstetrics. Virtually all of the specialists practice in communities of 25,000 people or more. But most of the deliveries in the small hospitals are in communities of less than 25,000.

The success of the Iowa program is no secret. Beginning some years ago Iowa hospitals and doctors formed a regional perinatal program which has emphasized screening and early referral of high risk patients. The majority of the high risk patients are delivered in the larger maternity services, where perinatal care centers have been established. Thus the larger services have a higher death rate, because they are handling most of the difficult deliveries.

Average delivery room charges for the Iowa hospitals increased steadily with increase in size of the hospital, from $57.19 for those under 100 beds to $158.57 for those of 1,000 or more beds. Average charge per day for the hospital room and the nursery followed a similar scale, from $94.74 up to $144.

MSMA Group Insurance Administrator Gets Certificate



Thomas E. Yates, III (right), of Thomas Yates & Company of Jackson is awarded a special Certificate of Participation by William Ring, vice president, CNA Insurance, at the conclusion of the first annual American Institute of Professional Association Group Insurance Administrators First Business Seminar held at the Hyatt Regency O'Hare Hotel in Chicago, IL, Oct. 8-11, 1978. Yates, who administers the MSMA Association Sponsored Group Insurance Program, has just concluded a term as president of AIPAGIA.

AIPAGIA consists of large group insurance administrators located throughout the USA, representing over 1,000 professional and trade organizations, both here and abroad. The seminar was an intensive study course, bringing the administrator up-to-date on new products, new methods and answers to many questions involved with the successful administration of Association Group Insurance.

Dr. J. D. Hardy Named ACS First Vice President

University of Mississippi Medical Center faculty member Dr. James D. Hardy has been elected first vice president of the American College of Surgeons.

The Mississippi surgeon, internationally known for his contributions to organ transplantation, shock, and other surgical research, assumed the office at the group's annual meeting in San Francisco. Approximately 40,000 American surgeons make up the membership.

Professor of surgery and chairman of the department at UMC since 1955, Dr. Hardy is past president of the American Surgical Association, the Society of University Surgeons, the Southern Surgical Association, and the Society for Surgery of the Alimentary Tract, of which he was a founding member.

He has been visiting professor in more than 22 medical centers and has lectured in France, Australia, Scotland, England and Italy. The author or co-author of more than 400 scientific articles, 14 books, and producer of 40 movies of surgical techniques, Dr. Hardy is listed in *Who's Who in America* and *American Men of Science*.

Prior to coming to Mississippi as the first chairman of the UMC Department of Surgery, he was associate professor of surgery research at the University of Tennessee College of Medicine.

Rotarians Present Gift To UMC Kidney Programs



The Rotary Medical and Educational Foundation has presented a $20,900 gift to kidney disease programs at the University of Mississippi Medical Center in Jackson. The foundation's contributions to the UMC renal program total more than $80,000. UMC Vice Chancellor Dr. Norman C. Nelson, left, said that the funds are used to help buy needed equipment and assist Medical Center programs for Mississippians who have kidney diseases. With Dr. Nelson are, from right, Elliott Beard of Jackson, Rotary district 682 governor, and Willis N. Puckett of Columbus, foundation president.

Medical Center Adds to Faculty

The University of Mississippi Medical Center added two new faculty members in October.

Dr. Norman C. Nelson, UMC vice chancellor and School of Medicine dean, announced the appointments following approval by the Board of Trustees, Institutions of Higher Learning.

Dr. John P. Naftel joined the centerwide faculty as an instructor in anatomy, and Dr. Jane A. Sanders was named an instructor in radiology in the School of Medicine.

Dr. Naftel earned the B.S. and M.S. degrees at Auburn University. He holds a Ph.D. degree from the University of Alabama.

A B.S. graduate of Mississippi University for Women, Dr. Sanders earned the M.D. degree at the Medical Center. She interned at Touro Infirmary in New Orleans, and took residency training at New Orleans' Charity and City of Memphis Hospitals.

Auxiliary Members Attend Political Participation Workshop

The American Medical Political Action Committee (AMPAC) in cooperation with the Mississippi State Medical Association Auxiliary and MPAC sponsored a workshop on political participation especially for physicians' spouses in Mississippi at the Holiday Inn-Medical Center in Jackson on Oct. 17.

Faculty for the meeting consisted of AMPAC staff from Chicago, Peter B. Laver and Linda Hudson, and Mrs. Belle Chenault of Decatur, Alabama, secretary of the AMPAC Board of Trustees and AMA Auxiliary Past President.

The all-day program centered around practical political pointers in selecting, supporting and campaigning for political candidates. Some 40 members of the MSMA Auxiliary attended the workshop.



Ms. Linda Hudson of the AMPAC staff lectures workshop participants on how to effectively participate in the then-upcoming election campaign.

U. S. High Priority Health Problems Identified

At the annual meeting of the Georgia Public Health Association in Savannah recently, Dr. William H. Foege, director of the Center for Disease Control (CDC), announced the recent recommendations of CDC's national Advisory Committee on Programs and Policies. Although that committee identified approximately 65 health/disease problems of great significance in the United States, the 12 highest priority health problems (in alphabetical order) were as follows:

alcohol and its consequences,
cancers of medium to high incidence subject to successful intervention when detected early,
cardiovascular diseases of medium to high incidence and subject to successful intervention,
contamination of drinking water,
dental diseases (notably caries and periodontal),
diseases caused by substances in workplace,
infant mortality,
motor vehicle accidents,
newly recognized diseases and unexpected epidemics of public health significance,
nosocomial infections,
smoking and its consequences, and
vaccine preventable diseases of children.

Congress Refuses Major Health Changes

After a bizarre 48-hour-long swan song, the 95th Congress frantically adjourned leaving dead in its ashes most of the Carter Administration's major health proposals.

The leading casualty among the health bills was a hospital cost containment measure. Unexpectedly gaining Senate passage in a watered-down fashion late in the session, the Administration and its congressional leadership pulled out all stops to whisk it through the House. But strong opposition by a number of House members who refused to be stampeded and the concerted effort of the American Medical Association, the American Hospital Association, and other health groups kept the President's much wanted measure from passage.

Also left in the paper rubbish on the Hill were the Child Health Assessment Program, clinical laboratory regulations, drug law reform, and a rewrite of the health planning law, the latter gaining a second one-year extension.

Sen. Herman Talmadge's (D-Ga.) carefully worked plan to reshape Medicare-Medicaid reimbursement for hospitals through prospective reimbursement also received the ax in the turmoil of the adjournment.

Proposals sought by the AMA also failed when the bills to which they were attached became mired. One of the AMA proposals would have repealed Section 227 of the Social Security Act placing a limit on the reimbursement of teaching physicians.

The $56 billion appropriations bill for the Labor and Health, Education and Welfare Departments passed after adoption of compromise language covering federal funding for Medicaid abortions. The Health Services Bill containing authorizations for many public health service programs such as mental retardation and teenage pregnancy did clear the Congress. A provision for aid to hospitals to set up primary care centers was reduced to a demonstration program while the Health Maintenance Organization program was extended, but with less funding than the Administration sought. Aid for biomedical research also was approved and sent to President Carter.

INDEX

VOLUME XIX

January-December, 1978

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SUBJECT INDEX

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "N," News; "L," Letters to the Editor; "PP," President's Page; "RS," Radiologic Seminar; "BR," Book Review; "MLB," Medico-Legal Briefs; "AP," Auxiliary Page; the asterisk (*) indicates an original article in the Journal, and the author's name follows the entry in brackets. "Deaths," "Personals" and "New Members" are indexed under the letters "D," "P," and "M" respectively.

Matter pertaining to MSMA is indexed under "Mississippi State Medical Association." For the author index see page 248.

A

Abbott Laboratories
honors Dr. A. Van Dyke Hagaman for more than 50 years of practice, 200-N
Abdomen
gangrenous bowel obstruction [Barnctt] *1
Meckel's diverticulum [Ball] *63-RS
the acute afferent loop syndrome [Barnett et al] *26
whole body computed tomography in the abdomen [McCay] *96-RS
Abuse, Sexual
child sex abuse is not reported, 59-N
Acute Afferent Loop Syndrome
the acute afferent loop syndrome [Barnett et al] *26
Aging
and mental health [Vogel] *226
Alcoholism
the physician alcoholic — ARCH to recovery [Ayres] *110
Allergy
Medical Center hosts workshop, 220-N
American Association of Medical Assistants
AAMA — Mississippi society [Lockey] 15-E
state medical assistant receives national award, 21-N
Mississippi medical assistants attend symposium, 82-N
Mississippi medical assistants attend workshop, 106-N
American Blood Commission
Dr. F. Morrison heads national task force, 105-N
American College of Surgeons
Dr. James D. Hardy named first vice president, 241-N
American Medical Association
AMA begins public campaign, 53-N
AMA considers MSMA resolutions, 160-N
AMA encourages new blood [Evers] 156-PP
Auxiliary members attend political participation workshop, 242-N
cost commission report: answer before too late, 79-N
issues book on medical practice, 238-N
lists skateboarding safety rules, 221-N
physicians say there are enough hospital beds, 101-N
American Medical Association-Education and Research Foundation
dean thanks for AMA-ERF gift to UMC [Nelson] 22-L
why AMA-ERF? [Brent] 189-AP
Amyotrophic Lateral Sclerosis
A.L.S. in Kansas [Vemireddi and Crevoiserat] *201
See also p. 11 of the December issue.
Asbestos
SBH issues physician advisory on health effects of asbestos, 197-N
Ascites
the LeVeen peritoneal-jugular shunt [Martin] 53-E
Aspirin
MI study at UMC reports results, 218-N
Asthma
Christmas Seals sponsor information seminar, 222-N
Auxiliary to MSMA
auxiliary pages: [Hilbun] 62; [Rowlett] 155; [Brent] 189; [Rowlett] 233
grants nurse's loan, 20-N
members attend political participation workshop, 242-N
plans 55th annual session program, 76
the president's report on the 1978 convention of the AMA Auxiliary [Rowlett] 155-AP; the president's report [Rowlett] 233-AP
why AMA-ERF? [Brent] 189-AP

B

Barnes, Helen B.
appointed to PSRO advisory council, 240-N
Battered-Child Syndrome
the battered-child syndrome and its management [Vogel] *23
Blood and Blood Banking
blood viscosity determinations directly from the vein [Philpot et al] *89
Dr. F. Morrison heads national task force, 105-N
UMC now has blood cell separator, 199-N
Blue Cross-Blue Shield of Mississippi
covers drug addiction treatment, 160-N
holds claims filing workshops, 175-N
Book Reviews
Current Pediatric Diagnosis and Treatment. 5th edition. By Kempe, Silver and O'Brien. [Conner] 142-BR
God, Man and Medicine. By Charles A. Hoffman. [Davis] 237-BR
Mealtime Manual for People with Disabilities and the Aging. [Armstrong] 214-BR
"Review A Book": *Mealtime Manual for People with Disabilities and the Aging; The Health Practitioner in Family Relationships; Current Obstetric and Gynecologic Diagnosis and Treatment; General Urology* (all listed on p. 174)
Sniff, Sniff, AL-ER-GEE. By Claude A. Frazier. [Mitchell] 192-BR
Bowel
gangrenous bowel obstruction [Barnett] *1
Brown, Hugh P.
inducted into Scoliosis Research Society, 217-N
Burkitt, Denis
speaks at UMC, 59-N

C

Callender Memorial Scholarship
first scholarship is awarded at UMC, 176-N
Cancer (See also **Carcinoma** and **Oncology**)
pain in malignancy: cordotomy [Sanford and Patrick] *46
Cardiology
aspirin MI study reports results, 218-N
Cardiobacterium Hominis endocarditis: a case report [Pankey and Horton] *107
definitive correction of congenital heart disease in infancy [Crawford et al] *179
Cardiovascular Disease (See also **Cardiology** and **Surgery**)
Cates Plaza
is planned for Ridgeland area, 120-N
Central Medical Society
publishes pictorial directory, 59-N
Chamber of Commerce
of U. S. endorses Carter's health principles, 216-N
Chiropractic
Mississippi Supreme Court defines practice of medicine, 176-N
Ciba Pharmaceutical Company
Nancy Tatum wins award at UMC, 219-N
Colon Disease (See also **Bowel** and **Abdomen**)
the case for the clean colon [Ellison] *50-RS
tubular hindgut colonic duplication: report of a case [Hughes and Ray] *223
Computerized Axial Tomography
whole body computed tomography in the abdomen [McCay] *96-RS
Congenital Heart Disease
definitive correction of congenital heart disease in infancy [Crawford et al] *179
Continuing Medical Education
CME accreditation is reported, 200-N
Continuing Medical Education [Lockey] 191-E
CPE — how much of a good thing is a good thing? [Evers] 170-PP
Forrest General Hospital announces CME seminar, 200-N
the continuing controversy of C.P.E. [Dabney] 211-E
Conerly, A. W.
named to respiratory therapy board, 174-N
Cordotomy
pain in malignancy: cordotomy [Sanford and Patrick] *46
Counsel to Authors
p. 95

D

Davis, J. T.
is named Mississippi Foundation for Medical Care medical director, 120-N
Death Filing Procedures
SBH death certificate filing improves, 56-N
Deaths
Bass, James C., Jr., 18
Beasley, James M., 212
Brumfield, Robert Hugh, 212
Cottrell, Hugh B., 158
DiSanti, Nicholas, 80
Hewes, A. C., 193
McVey, Eric A., Jr., 80
Norwood, Carl W., 158
Pegues, J. C., 18
Powell, John E., 212
Riley, George E., 158
Schwartz, Robert E., 141
Smith, Gerald A., 119
Smithson, William A., 193
St. Germain, Ellis L., 54
Strange, W. W., 80
Werkheiser, Frank E., 119
Wilde, Adna G., 18
Dental Care
fluorides and the physician: an update [Trubman] *205
Diabetes
Mississippi participates in diabetes control project, 58-N
Drug Abuse
Blue Cross-Blue Shield of MS covers drug addiction treatment, 160-N
Drugs
frequency of drug administration [Fischer] *161
provision of government-financed outpatient drug programs in Texas and California [Olsen] 192-L
Durfey, A. P., Sr.
gets 'Golden Deeds' award, 104-N

E

Electrocardiography
physicians take EKG intensive course at UMC, 21-N
Emergency Medical Care Unit
Doctor of the Day is honored, 59-N
opens at Capitol, 40-N
Emergency Medicine
emergency treatment of shock — use of medical antishock trousers (MAST) [Lowe] *147
Endocarditis
Cardiobacterium Hominis endocarditis: a case report [Pankey and Horton] *107

F

Family Practice
family practice review course draws physicians, 20-N
Family Practice Specialist
family medicine workshop held at UMC, 199-N
UMC family medicine fund receives gift from Mississippi Academy of Family Physicians, 86-N
Ferris, Lucian
poem "To Dr. Ferris" [Roach] 225
Fetus
ultrasound evaluation of some fetal abnormalities [Bouchillon] *114-RS
Finch, Cliff
atop health planning pyramid [Back] *230
Senate voids Governor Finch's State Board of Health appointees, 103-N
State Board of Health controversy erupts again, 40-N
Fire Ants
seeks information on fire ant hazard [Frazier] 33-L
Federal Trade Commission
the Federal Trade Commission [Lockey] 139-E
Fluorides
and the physician: an update [Trubman] *205
Forrest General Hospital
announces CME seminar, 200-N
Fungus Disease
Jackson hosts symposium on, 87-N

G

Gynecology
Brenner tumor of the ovary — ultrasound findings [Williams] *168-RS

H

Hagaman, A. Van Dyke
honored by Abbott Labs for more than 50 years of practice, 200-N
Hardy, James D.
named first vice president of American College of Surgeons, 241-N
Hair Transplants
symposium is set, 241-N
Health Care Costs
Brookings predicts deficit from NHI, 188-N
cost commission report: answer before too late, 79-N
frequency of drug administration: a prime factor in patient compliance and health care cost [Fischer] *161
health expenditures rise in U. S., 19-N
medical care costs — a public concern [Evers] 234-PP
MSMA and Mississippi Hospital Association (MHA) announce cost containment program, 103-N
MSMA and MHA seek cost containment, 40-N
small hospitals safe and less costly for babies, 240-N
the escalating cost of medical care — everyone has a solution; no one has the answer [Dabney] 31-E
the problem of inflation [Dabney] 99-E
Health Care Financing Administration (HCFA)
Dr. Helen Barnes appointed to PSRO advisory council, 240-N
Medicaid/Medicare draw criticism, 104-N
Health, Education and Welfare, Department of
Finch atop health planning pyramid [Back] *230
HEW announces second surgical opinion programs, 177-N
Mississippi is critical shortage area, 57-N
MSMA protests planning guidelines, 20-N
Tennessee PSRO is shut down, 217-N
Health Manpower
the State Board of Health manpower project [Lynch et al] *151
Health Planning and Development Act
Finch atop health planning pyramid [Back] *230
Hepatitis
prophylaxis is discussed, 102-N
Hernia
the air-fluid level in the retrocardiac space [Colbert] *28-RS
Herpes Viruses
UMC graduate student demonstrates Herpes enzyme, -N
Hospitals
physicians say there are enough hospital beds, 101-N
small hospitals safe and less costly for babies, 240-N
Hypertension
May is high blood pressure month [Gibson] 99-E
Medical Center sponsors hypertension seminar, 87-N
the first three years of blood pressure screening by the Mississippi Heart Association [Sharpe] *5

I

Immunization
importance of measles immunization requirements emphasized [Blakey] 211-L
Influenza
vaccine for 1978-79 reported by MSBH, 216-N

J

Joint Commission on Accreditation of Hospitals
urges validation of staff privileges, 60-N
Journal MSMA
exception taken to Journal article on St. Paul insurance [Roeder] 157-L
it's your Journal [Dabney] 157-E
Journal MSMA scores high in readership survey, 32-N

K

Kidney
evaluation of renal mass lesions [Cranston] *134-RS
Rotarians present gift to UMC kidney programs, 241-N

L

Laboratory Sciences, Clinical
blood viscosity determinations directly from the vein [Philpot et al] *89
Legislation
Congress refuses major health changes, 242-N
quackery by legislation [Martin] 117-E
saved by the bell [Martin] 235-E
Letters to the Editor
dean thanks for AMA-ERF gift to UMC [Nelson] 22-L
seeks information on fire ant hazard [Frazier] 33-L
silicone study announced [Pollock] 142-L
treatment of bacterial meningitis [Blakey] 34-L
Leukemia Society of America, Inc.
funding is available for research, 102-N
LeVeen Peritoneal-Jugular Shunt
the LeVeen peritoneal-jugular shunt [Martin] 53-E
Liver
subcapsular hematoma of the liver [Warren] *186-RS
Longest, John C.
directs smoking and health program, 86-N
Lungs
clinical diagnosis of pleural disease [Griffith and Campbell] *41
lung disease symposium set for Georgia, 86-N

M

Malabsorption
clinical and laboratory evaluation of malabsorption [Wilson] *183
Malignancy (See also **Cancer** and **Carcinoma**)
pain in malignancy: cordotomy [Sanford and Patrick] *46
Maternal Mortality
case report XVIII of Maternal Mortality Study [Walley] *93
Measles
need for immunization programs emphasized [Blakey] 211-L
Medicaid
factors affecting physician participation in the Mississippi Medicaid program [Garner et al] *129
Medicaid fee increases are implemented in Mississippi, 143-N
Medicaid/Medicare draw criticism, 104-N
Medical Association of Georgia
sets joint meeting with Southern Medical Association, 220-N
Medical Antishock Trousers (MAST)
emergency use of [Lowe] *147
Medical Practice
AMA issues book, 238-N
medical science redefines thinking on what is normal, 145-N
Mississippi Supreme Court defines practice of medicine, 176-N
Medicare
fees are lowest in Mississippi, 215-N
HEW announces second surgical opinion programs, 177-N
Medicaid/Medicare draw criticism, 104-N
Medicine, Internal
Cardiobacterium Hominis endocarditis: a case report [Pankey and Horton] *107
Medico-Legal Briefs
anesthesiologist not liable for patient's cardiac arrest, 53-MLB
effect of refilling drug prescription on physician-patient relationship, 171-MLB
M.D. has no claim against attorneys for settling suit, 143-MLB
MD's successful countersuit reversed by appellate court, 235-MLB
court dismisses suit by physicians against patient and attorneys, 100-MLB
missed checkup a defense in medical malpractice suit, 31-MLB
subpoenas for hospital committee's records not enforceable, 191-MLB
the Bakke case, 15-MLB
Members, New
Anderson, William J., 17
Anis, Onssy H., 17
Arhelger, Roger B., 17
Aseme, Kate N., 193
Bailey, Joseph N., III, 117
Balzli, Joseph T., 140
Barksdale, Bryan, 80
Bazzone, Victor T., 17
Borrell, Luis, 34
Buckalew, Roland E., 117
Burrow, William Hollis, II, 193
Caine, Curtis W., Jr., 55
Cargile, Kenneth R., 80
Carr, Thomas Martin, 193
Carter, Michael H., Jr., 17
Chappell, Joseph J., Jr., 34
Cockrell, Marion E., Jr., 193
Collier, Richard E., Jr., 193
Collins, Frank B., 117
Collins, Robert K., 117
Cooper, Robert F., III, 193
Crawford, Benjamin L., III, 159
Crawford, John C., 117
Crowder, Herman R., III, 35
Crowell, Jack W., 173
Crowson, Thomas D., 212
DeBessonet, David A., 117
Diaz, Albert L., 193
Doolittle, Philip Dexter, 17
Fenter, Thomas C., 35
Flores, Thomas R., 80
Flowers, Harvey A., 118
Funderburg, James C., 173
Ganaraj, P. S., 17
Garrott, Thomas C., 140
Gersh, H. Allen, 118
Gilbert, John B., 118
Goff, Jan T., 193
Hall, Donald S., Jr., 140
Hamilton, Jimmy Lynn, 193
Harper, Gerald H., 35
Heckler, Frederick R., 118
Henry, John Kelly, 159
Herrin, Thomas Jones, Jr., 118
Hobb, Milton D., 174
Hudgins, James J., 118
Hutchins, Kelly E., 35
Hutchins, Wiley C., 80
Irby, Braxter P., Jr., 212
Isbell, Jimmy E., 118
Jones, Bruce McAlphin, 17
Jones, Ken C., 80
Kim, Achin, 193
Kuiper, Hendrik K., 55
Lackey, Van L., 35
Lipscomb, Larry R., 80
Madara, Jose, 55
Mayfield, William C., Jr., 17
McAuley, Malcolm D., 80
Mahalak, Lawrence W., Jr., 17
Morneau, James E., 118
Nudurft, Joseph H., 17
Parvin, Thomas S., 118
Patel, P. P., 18
Petro, Anthony B., 18
Pettit, Paul N., Jr., 174
Price, Thomas H., 118
Profilet, William B., Jr., 194
Purohit, Surendra K., 35
Reed, John E., Jr., 80
Rhoden, Richard E., 80
Rhoden, Sandra A., 118
Robertson, Paul A., 118
Robinson, George R., 18
Robinson, John W., 18
Robinson, Joseph H., 35
Ross, Sidney O., Jr., 194
Rubenstein, Louis A., 118
Russell, Robert P., 18
Saltz, Isaac Harry, 212
Seith, William F., Jr., 35
Sheffield, Thomas E., 35
Simmons, Sue H., 18
Sones, James Q., II, 80
Smith, Prentiss L., 18
Stevens, William W., III, 18
Stewart, Garland S., Jr., 118
Stancill, Hugh W., III, 35
Stringer, Douglas L., 140
Suares, Robert N., 35
Suber, Barry D., 55
Sumners, William E., 140
Thomas, Douglas F., 119
Van Deventer, W. H., 119
Vanvinh, Nguyen, 140
Vaughan, Thomas A. J., 18
Vilardi, Paul, 174
Waller, Richard E., 141
Watson, David G., 140
Wells, Thomas G., 119
Wesson, Matthew B., 141
Wilson, Roy D., 119
Wiser, Winfred L., 18
Wooldridge, Thomas D., 80
Young, Walter Russell, 119
Meningococcal Disease
State Board of Health reports on it in Mississippi, 37-N
Mental Health
aging and mental health [Vogel] *226
Microsurgery
an expanding field [Lockey] 79-E
Mississippi, State of
Mississippi is critical shortage area, 57-N
Mississippi Academy of Family Physicians
gives gift to UMC Family Medicine fund, 86-N
meets at Biloxi, 178-N

Mississippi Baptist Medical Center
sponsors fungus disease symposium, 87-N
Mississippi Society, American Association of Medical Assistants
AAMA-Mississippi Society [Lockey] 15-E
medical assistants attend workshop, 106-N
Mississippi medical assistants attend symposium, 82-N
state medical assistant receives national award, 21-N
Mississippi Foundation for Medical Care
Dr. J. T. Davis is named medical director, 120-N
Mississippi Heart Association
May is high blood pressure month [Gibson] 99-E
the first three years of blood pressure screening by MHA [Sharpe] *5
Mississippi Health Systems Agency
Finch atop health planning pyramid [Back] *230
Mississippi Hospital Association
and MSMA announce cost containment program, 103-N
MSMA and MHA seek cost containment, 40-N
Mississippi Lung Association
Christmas Seals sponsor asthma information seminar, 222-N
pediatric pulmonary case conference is scheduled, 176-N
sponsors fungus disease symposium, 87-N
Tri-State thoracic conference convenes, 58-N
Mississippi Medical Fraternal and Educational Society (MMFES)
general manager is named, 143-N
reports phenomenal growth, 160-N
Mississippi Medical Political Action Committee (MPAC)
Auxiliary members attend political participation workshop, 242-N
supports state political winners, 160-N
Mississippi Orthopaedic Society
central Mississippi chapter meets, 58-N
Mississippi State Board of Health
appointments controversy erupts again, 40-N
death certificate filing improves, 56-N
fluorides and the physician: an update [Trubman] *205
hepatitis prophylaxis is discussed, 102-N
influenza vaccine 1978-79 reported on, 216-N
issues physician advisory on health effects of asbestos, 197-N
Mississippi participates in diabetes control project, 58-N
reports on meningococcal disease in Mississippi, 37-N
senate voids Finch's appointees, 102-N
the health manpower project [Lynch et al] *151
treatment of bacterial meningitis [Blakey] 34-L
Mississippi State Medical Association
address of the president [Gilmore] *132
AMA considers MSMA resolutions, 160-N
and Mississippi Hospital Association announce cost containment program, 103-N; MSMA and MHA seek cost containment, 40-N
Auxiliary — grants nurse's loan, 20-N; auxiliary page [Hilbun] 62-AP; auxiliary page [Rowlett] 155-AP; auxiliary plans 55th annual session program, 76-N; auxiliary page — why AMA-ERF? [Brent] 189-AP; auxiliary page — the president's report [Rowlett] 233-AP
Board of Trustees — Board considers full agenda at regular summer meeting in Tupelo, 175-N; Board of Trustees holds fall meeting, 19-N; meets in Jackson, 85-N; names 1978-79 officers, 124-N
Central Medical Society — publishes pictorial directory, 59-N
CME accreditation is reported by Council on Medical Education, 200-N
comments on health plan, 56-N
Emergency Medical Care Unit — Doctor of the Day is honored, 59-N; EMCU opens at Capitol, 40-N
group insurance administrator receives certificate, 241-N
Journal MSMA — it's your journal [Dabney] 157-E; scores high in readership survey, 32-N
Mississippi Supreme Court defines practice of medicine, 176-N
MMFES — general manager is named, 143-N; reports phenomenal growth, 160-N
MPAC — Auxiliary members attend political participation workshop, 242-N; supports state political winners, 160-N
President's page — [Gilmore] — "Some New Year's Resolutions," 14-PP; "Congress and Medicine: 1977 Was a Good Year," 30-PP; "Public Ambivalent on Health Care," 52-PP; "Are We Giving It Away?" 78-PP; "More Controls," 98-PP
President's page [Evers] — "What Can MSMA Do for Me?" 116-PP; "Where Are We?" 138-PP; AMA Encourages New Blood," 156-PP; "CPE — How Much of a Good Thing is a Good Thing?" 170-PP; "A Professional and Public Consensus on Health," 190-PP; "Identifying Rural Medical Care Needs," 210-PP; "Medical Care Costs — A Public Concern," 234-PP
protests planning guidelines, 20-N
sponsors workshop attended by medical assistants, 106-N
State Board of Health controversy erupts again, 40-N
110th Annual Session — the 110th Annual Session of MSMA is scheduled for May 1-4 at Jackson, 39-N; MSMA's big 110th Annual Session approaches, 57-N; official call and program, 65; Dr. Carl G. Evers is inaugurated president, Dr. Gerald P. Gable is named president-elect, 121-N; specialty societies hold concurrent meetings, 126-N
111th Annual Session — scientific assembly begins work for '79, 125-N; the Council on Scientific Assembly plans 111th annual session, May 6-10, 1979, 197-N
1979 MSMA-Robins Award is announced, 239-N
Mississippi State University
C. B. Mitchell Lecture is this month, 85-N
Dr. Longest directs smoking and health program, 86-N
Mississippi Thoracic Society
annual meeting hears Boswell Lecture, 144-N
Christmas Seals sponsor asthma information seminar, 222-N
pediatric pulmonary case conference is scheduled, 176-N
Morrison, Francis S.
heads national task force, 105-N
Myocardial Infarction
aspirin study at UMC reports results, 218-N

N

National Health Insurance
Brookings predicts deficit from NHI, 188-N
Chamber of Commerce endorses Carter's health principles, 216-N
National Health Planning and Resources Development Act of 1974
Finch atop health planning pyramid [Back] *230
MSMA comments on health plan, 56-N
MSMA protests planning guidelines, 20-N
Neurology
Amyotrophic Lateral Sclerosis in Kansas [Vemireddi and Crevoiserat] *201
the T.I.A. pitfall [Yates and Stringer] *228-RS
update is scheduled, 220-N
Newborn Care (Neonatology)
definitive correction of congenital heart disease in infancy [Crawford et al] *179
Medical Center sponsors newborn art contest, 101-N
winner of UMC newborn art contest is announced, 177-N
Nursing
first Callender Memorial nursing scholarship is awarded at UMC, 176-N
MSMA Auxiliary grants nurse's loan, 20-N

O

Orthopedic Surgery
upper extremity problems studied at UMC, 219-N
Osteomyelitis
radionuclide bone scanning in the diagnosis of acute osteomyelitis [Hankins and Flowers] *10-RS
Owen, J. Lee
wins in Kodak competition, 106-N

P

Pain
pain in malignancy: cordotomy [Sanford and Patrick] *46
UMC now has pain clinic, 216-N
Pediatrics
definitive correction of congenital heart disease in infancy [Crawford et al] *179
pediatric pulmonary case conference is scheduled, 176-N
the battered-child syndrome and its management [Vogel] *23
Personals
Abide, John K., 194
Adams, Hans W., 194
Aftandilian, Emil, 16
Ahmed, Afzal, 32
Aiken, Robert E., 194
Anderson, Glen, 142
Arrington, George L., Jr., 54
Arnola, Rodolfo N., 100
Ascanio, Peter, 141
Aultman, Isaac, 54, 159
Austin, Will K., 54
Aycock, Larry, 16
Ball, David, 236
Ball, Leonard, 237
Barkley, T. J., 213
Bass, Ross F., 100, 101
Baxter, M. D., 55
Bazzone, Victor T., 54
Bell, Charles, 142
Bell, Walterine, 142
Berry, Donald R., 16
Bennett, Glenn Harris, 158
Benoist, Louis A., 194
Bertucci, Gregory, 194
Bishop, Hal D., 236
Blake, Thomas H., Jr., 194
Blake, Thomas M., 172
Blakey, Durward, 54
Bland, Griffin, 158
Blanton, T. D., 194
Blaylock, Darrell N., 194
Blissard, Thomasina, 142, 158
Boggan, Willard H., 141
Bolton, D. L., 172
Bolton, Eldon L., 32
Boone, Walter T., 32
Boren, Ronald P., 54
Boronow, Richard C., 81
Bowlin, John W., 32, 214
Brahan, Robert B., 236
Briggs, Frank R., 54
Brown, Hugh P., 16, 101
Brown, James L., 194
Bruce, J. V., 158
Bryant, Thomas R., 54, 159
Buckalew, Roland, 54
Buckley, Robert L., Jr., 172, 236
Buckley, Theresa L., 32, 158, 236
Bumgardner, Joe R., 213
Burgess, C. Duane, 32
Busey, John, 141, 159
Cabell, Thomas H., 195
Caldwell, R. E., 54
Caldwell, Wallace E., 214
Camero, Francisco, 54
Campbell, Guy, 159
Carey, Tom, 16
Carmichael, George, 236
Carruth, Edward L., 100
Carter, Kenneth G., 81
Carter, Robert F., 194
Castle, Robert F., 119
Catchings, C. E., 172
Chapman, John D., 32
Charlesworth, Ernest N., 158
Chase, Vernon, 100
Chauvin, Russell, 54
Chevis, Sidney A., 32
Christman, Eric, 32
Clay, John C., 194, 236
Cobb, Alton B., 159, 214
Coggin, Robert L., 194
Coghlan, Robert, 54
Cole, E. H., 142
Coleman, Michael, 158
Conerly, A. Wallace, 158
Cone, Francis R., 172
Cook, Lewis H., 81
Cooke, R. S., 214
Cooper, James, 54
Cordova, Ernesto D., 236
Costilow, Millard S., 159
Christman, J. Eric, 214
Crowson, Thomas D., 194
Curry, Max, 32
Davidson, Edwin M., 236
Davis, Cliff, 142
Davis, Woody, 54
De Berardinis, Michael C., 141, 159
Dilworth, Robert, 54
Doster, Vernon W., 159
Draper, Edgar, 142
Draughn, Daniel H., 159
Dunnihoo, Dale R., 194
Durfey, A. P., Sr., 54
Durfey, A. P., Jr., 236
Easterly, Clay, 81

Ennis, Calvin S., 236
Estess, Robert E., 159
Evans, S. R., Jr., 119
Evers, Carl, 119
Fabian, Judith A., 236
Fairchild, Hilton M., 16
Fellows, William R., 172
Ferguson, Grace R., 32
Fite, James W., 194
Flood, John B., 194
Flowers, W. Mel, Jr., 81
Floyd, Charles N., 119, 236
Flynt, Mayo, 214
Fulcher, Harry, 159
Furr, Richard T., 32
Gaines, Kenneth J., 16
Galloway, Sam, 54
Gandy, Thomas, 81
Gary, William, 81
Gersh, H. Allen, 16
Gibson, John Y., 81
Gibson, William J., Jr., 159
Giles, H., 236
Glasgow, Thomas S., 172
Gilmore, James O., 172
Godbey, Marion, 159
Goss-Moffitt, Nina B., 142
Graham, Robert M., 54
Hagood, Clyde O., 81
Hall, William L., 16
Hamilton, Jimmy L., 172
Hamblin, O. Lynn, 54
Hammett, Larry J., 16
Hamway, Sammy A., 214
Hanes, L. C., 142
Hardy, James D., 16, 119
Harrell, F. J., 16
Harrell, Rebecca S., 81
Harrison, R. W., 159
Hartness, Stanley, 141
Hasseltine, Hanley E., 194
Hatten, Lewis, 32
Heath, Bobby J., 194
Heitzman, H. Brad, 33
Henderson, Robert P., 32, 101
Hewes, Thomas Finley, 172
Hicks, G. Swink, 141
Hill, J. Ed, 54
Hill, Purvis W., Jr., 33, 81
Hinman, M. E., 54
Hogue, Charles, 32
Holder, E. J., 194
Holcomb, Barry, 54
Hollis, Allen U., 100
Holloway, James P., 141
Holman, Charles M., Jr., 194
Holmes, Verner S., 159, 236
Hopkins, Donald A., 16
Hubbard, William James, Jr, 236
Hutchins, Kelly E., 16
Hutchinson, Richard G., 32
Iles, Jerry W., 141
Jabaley, Michael E., 194, 236
Jackson, A. C., 81
Johnson, Ben B., 236
Johnson, Cleve E., 194
Johnson, H. Richard, 54
Johnson, Samuel B., 81
Johnson, W. Cecil, 159
Jones, Daniel W., 159
Jones, Edley, Sr., 33
Jones, Walter R., Jr., 54
Jordan, C. M., 236
Kahlstorf, William L., 16
Keady, Dwight S., 141
Knight, Charles S., 159
Lane, Dewey H., 16
Langford, Herbert G., 194
Lansden, Frank, 81
Lee, Albert Ray, Jr, 142, 159
Lee, John Paul, 195
Lee, Mary Alice, 101
Lee, Lynda G., 195
Lee, Mercer, 172
Levens, John, 195
Lindsey, Arthur, 54
Little, Robert Ashford, 16, 101, 195
Lockey, Myron, 101
Longest, John C., 33
Longnecker, M. F., Jr., 236
Love, Milas S., III, 236
Love, Robert T., Jr., 101
Love, S. Kimble, 33, 101
Lowicki, Edward M., 119
Lynch, M. B., 81
Maggio, Henry, 237
Mangrem, Carole, 172
Maniktahla, Kanwal N., 195
Martin, Arthur M., Jr., 142
Martin, Frank G., 33, 142
Matthieu, Donald E., Jr., 214
May, Robert Odell, 195
Meadows, David L., 159
Meek, Edwin M., Jr., 119
Melvin, James H., 158
Messina, A. J., 81
Middleton, Robert, 32
Miles, Charles D., 214
Mitchell, Don Q., 214
Mitchell, Ernest H., Jr., 214
Mitchell, Shelby, W., 236
Mladineo, John P., 214
Moak, W. E., 142
Moffit, Ellis M., 54
Mora, Marcelo L., 142
Morgan, John D., 32
Morgan, Mal, 236
Morris, Gary N., 101
Morris, Glenn F., 54, 159
Morrison, Francis S., 101, 172, 195
Morse, John P., 236
McCrory, Henry A., 54
McFarland, Cortez, 195
McFarland, Thomas, 172
McGraw, David B., 172
McIlwain, James S., 159
McMillan, Fred L., 54
McMullan, Martin H., 16
McRae, John M., 236
McRae, A. Thomas Jr., 101
McQuinn, William C., 119, 142
Murray, John P., 194
Myers, Beverly W., 195
Myers, Robert P., 195
Naef, Richard W., 16
Nelson, John C., 142
Nelson, Norman C., 119, 172
Nichols, Frank A., 214
Nicholls, Richard A., 16
Nievas, Hugo C., 214
North, Ed, 195
Odom, Paul L., 81
Orgler, Raymond J., 195
Owens, Jennings, 172
Paine, Thomas D., 159
Parvin, T. S., 195
Pate, S. Ray, 119
Patel, Bharat R., 16
Patel, Jaishri B., 16, 54
Patel, M. L., 101
Pettit, Paul N., Jr., 195
Petro, Anthony B., 54
Peurifoy, J. Tom, Jr., 195
Pineda, Mario, 236
Phelps, C. S., 81
Pontius, William, 32, 159
Porter, John A., 54
Prater, Wesley, 195
Price, E. J., Jr, 101
Puckett, T. F., 214
Puckett, T. G., 214
Raffel, Bruce, 159
Ralling, Wallace A., 236
Ratcliff, James G., 214
Ratliff, Donald, 172
Ratliff, Leon, 172
Rausa, Alfio, 33
Rawson, John, 17
Ray, Charles, 81
Rayner, Donald, 81
Reed, Roger H., 54
Reed, William J., 195
Rennick, Ron, 81
Rhoden, Richard, 119, 142
Richardson, David D., 54
Risch, E. David, 236
Roark, G. Allen, 236
Robertson, Gerald M., 32, 142, 172
Robertson, Paul A., 81
Robertson, Roland, 159
Robinson, Joseph H, 101
Rose, Walter H., 54, 159
Runnels, Gathel O., 32
Russell, John B., 236
Russwurm, D., 236
Rutherford, J. D., III, 32
Saltz, Harry, 17
Sams, James H., 101
Sanders, Henry, 16
Sandifer, Fred, Jr., 54
Sartin, Jack, 54
Sbardella, Edward F., Jr., 214
Scanlon, Leo, 54, 142
Schmidt, Harry, Jr., 159
Segars, Kelly, 159
Seidensticker, William L., 172
Senter, Jack, 172
Sexton, Frederick George, 81
Shaw, G. Boyd, 32, 159
Shirley, James H., 214
Siegler, Roland E., 159
Simmons, Samuel J., III, 33
Skiwski, Jacob, 172
Smith, J. L., 214
Smith, Perrin N., 214
Smith, Robert R., 54, 81
Smith, Steve, 142
Springer, Joseph G., 81
Stewart, G. Seale, 101
Stewart, W. K., 237
Strange, D. C., 195
Stubblefield, Earl T., 159
Sumners, W. E., 17
Tabb, W. Granville, 54
Tadros, R. R., 55
Tarpy, Patrick E., 195
Taylor, C. D., Jr., 195
Thigpen, James Tate, 32, 33, 81, 119
Thornton, Bill, 33
Todd, James Roy, Jr., 159
Towler, H. Howell, Jr., 101
Trapp, James T., 81
Trouche, Perry, 237
Truly, William, 17
Turnbull, Edward R., 194
Vilardi, Paul J., 54
Wade, Frank, 119
Wadsworth, H. M., Sr., 55
Waller, Richard, 119
Warren, Kenneth R. W., 172
Warrington, James, 119
Watkins, Clyde, 159
Wells, Peggy J., 172
Wesson, Roy, 32
Whaley, Lance D., 194
Wicker, Ralph T., 159
Wilkerson, George E., 32
Williams, Cecil T., Jr., 159
Williams, Jacob M., 142
Williams, M. Ney, 101
Wimberly, John A., 195
Wyatt, Rhea L., 81
Yelverton, Richard L., 54, 172
Young, John R., Jr., 195, 236
Zamora, Ivan V., 195
Zaslow, Lawrence, 101, 214

Pesticides
physicians are urged to report pesticide incidents [Lane] 191-L
reporting of pesticide incidents is urged, 215-N

Pharmacy
frequency of drug administration [Fischer] *161

Physicians
factors affecting physician participation in the Mississippi Medicaid program [Garner et al] *129
fluorides and the physician: an update [Trubman] *205
the physician alcoholic — ARCH to recovery [Ayres] 110-N

Pituitary
tumor conference planned at UMC, 200-N

Postgraduate Calendar
schedules published on pages 13, 35, 55, 81, 94, 117, 141, 158, 173, 195, 212, 237

Psychiatry
aging and mental health [Vogel] *226
the battered-child syndrome and its management [Vogel] *23

Professional Liability Insurance
MMFES general manager is named, 143-N
MMFES reports phenomenal growth, 160-N
St. Paul takes exception to Journal MSMA article [Roeder] 157-L

Professional Standards Review Organizations (PSRO)
cites surgical procedures, 60-N

Dr. Helen Barnes appointed to PSRO advisory council, 240-N
Dr. J. T. Davis is named MFMC medical director, 120-N
Tennessee PSRO is shut down, 217-N
Pulmonary Disease
clinical diagnosis of pleural disease [Griffith and Campbell] *41
pediatric pulmonary case conference is scheduled, 176-N

Q

Quackery
quackery by legislation [Martin] 117-E

R

Radiologic Seminars
CLXXVII: radionuclide bone scanning in the diagnosis of acute osteomyelitis [Hankins and Flowers] *10-RS
CLXXVIII: the air-fluid level in the retrocardiac space [Colbert] *28-RS
CLXXIX: the case for the clean colon [Ellison] *50-RS
CLXXX: Meckel's diverticulum [Ball] *63-RS
CLXXXI: whole body computed tomography in the abdomen [McCay] *96-RS
CLXXXII: ultrasound evaluation of some fetal abnormalities [Bouchillon] *114-RS
CLXXXIII: evaluation of renal mass lesions [Cranston] *134-RS
CLXXXIV: Brenner tumor of the ovary — ultrasound findings [Williams] *168-RS
CLXXXV: subcapsular hematoma of the liver: a case report [Warren] *186-RS
CLXXXVI: atlantoaxial rotation subluxation [Clark] *208-RS
CLXXXVII: the T.I.A. pitfall [Yates and Stringer] *228-RS
Radiology
acute radiology update is scheduled, 240-N
Respiratory Therapy
Dr. A. W. Conerly named to Respiratory Therapy Board, 174-N
Rheumatology
UMC schedules clinical rheumatology seminar, 199-N
Rotary Clubs
present gift to UMC kidney program, 241-N

S

Safety
skateboarding rules are listed, 221-N
Scoliosis
Dr. Hugh P. Brown inducted into research society, 217-N
Second Surgical Opinions
HEW announces program, 177-N
Skateboarding
safety rules are listed, 221-N
Smoking
Dr. Longest directs smoking and health program, 86-N
Snakebite
poisonous snakebite [Martin] 171-E
Southeastern Surgical Congress
New Orleans will host 46th annual congress, 22-N
Southern Medical Association
sets joint Nov. meeting with Medical Association of Georgia, 220-N
Stings, Insect
request for information on fatal reactions to insect stings, etc. [Frazier] 157-L
St. Paul Insurance Company
takes exception to Journal MSMA article [Roeder] 157-L
Stroke
the T.I.A. pitfall [Yates and Stringer] *228-RS
Surgery
definitive correction of congenital heart disease in infancy [Crawford et al] *179
gangrenous bowel obstruction [Barnett] *1
HEW announces second surgical opinion program, 177-N
microsurgery — an expanding field [Lockey] 79-E
pain in malignancy: cordotomy [Sanford and Patrick] *46
the acute afferent loop syndrome [Barnett et al] *26
the LeVeen peritoneal-jugular shunt [Martin] 53-E
tubular hindgut colonic duplication: report of a case [Hughes and Ray] *223

T

Tatum, Nancy O'Neal
wins UMC Ciba award, 219-N
Tomography
whole body computed tomography in the abdomen [McCay] *96-RS
Tri-State Thoracic Conference
convenes, 58-N
Tulane University
medical alumni plan homecoming, 196-N

U

Ultrasound
Brenner tumor of the ovary — ultrasound findings [Williams] *168-RS
ultrasound evaluation of some fetal abnormalities [Bouchillon] *114-RS
U. S. Public Health Service (See also **Mississippi State Board of Health**)
high priority health problems in U.S. are identified, 242-N
Mississippi is critical shortage area, 57-N
University of Mississippi Medical Center (UMC)
adds to faculty, 21-N, 56-N, 85-N, 101-N, 200-N, 217-N, 241-N
aspirin MI study reports results, 218-N
dean thanks for AMA-ERF gift to UMC [Nelson] 22-L
Dr. A. W. Conerly named to Respiratory Therapy board, 174-N
Dr. Denis Burkitt speaks at UMC, 59-N
Dr. F. Morrison heads national task force, 105-N
Dr. James D. Hardy named ACS vice president, 241-N
Dr. R. M. O'Neal named pathology chairman, 105-N
family medicine fund receives gift, 86-N
family medicine workshop held, 199-N
family practice review course draws physicians, 20-N
first Callender Memorial Scholarship is awarded to nursing student, 176-N
has pain clinic, 216-N
holds commencement exercises, 144-N
hosts advanced cardiac life support course, 145-N
hosts allergy workshop, 220-N
hosts Boswell Lecturer, 144-N
hosts valentine party for former patients, 86-N
J. E. McDonald is top graduate, 145-N
MSMA Auxiliary grants nurse's loan, 20-N
Nancy Tatum wins CIBA award, 219-N
now has blood cell separator, 199-N
physicians take EKG intensive course, 21-N
pituitary conference planned, 200-N
releases registration figures, 215-N
Rotarians present gift to kidney programs, 241-N
schedules clinical reheumatology seminar, 199-N
sponsors gastroenterology update, 60-N
sponsors hypertension seminar, 87-N
sponsors newborn art contest, 101-N
studies temporal bypass procedure, 58-N
upper extremity problems studied, 219-N
will graduate 147 physicians, 105-N
winner of newborn art contest is announced, 177-N

Y

Yates, Thomas E., III
MSMA group insurance administrator gets certificate, 241-N

TABLE OF PAGES

January	1 to 22	July	129 to 146
February	23 to 40	August	147 to 160
March	41 to 62	September	161 to 178
April	63 to 88	October	179 to 200
May	89 to 106	November	201 to 222
June	107 to 128	December	223 to 248

AUTHOR INDEX

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "N," News; "L," Letters to the Editor; "PP," President's Page; "RS," Radiologic Seminar; "MLB," Medico-Legal Brief; "BR," Book Reviews; "AP," Auxiliary Page. The asterisk (*) indicates an original article in the Journal.

A

Armstrong, William R., 214-BR
Atkinson, Bruce, *89
Ayres, Perry R., *110

B

Back, Edith Bierhorst, *230
Ball, Ottis G., *63-RS
Barnett, William O., *1, *26
Black, Lewis, *89
Blakeney, H. J., *89
Blakey, Durward L., 34-L, 211-L
Bouchillon, C. D., *114-RS
Brantley, Mary, *151
Brent, Mrs. Alvin E., Jr., 189-AP

C

Campbell, Guy D., *41
Clark, Douglas E., *208-RS
Colbert, Walter T., *28-RS
Conner, O. Weir, 142-BR
Cranston, Philip E., *134-RS
Crawford, Fred A., Jr., *179
Crevoiserat, Charles A., Jr., *201

D

Dabney, W. Moncure, 31-E, 99-E, 157-E, 211-E
Davis, J. T., 237-BR

E

Ellison, R. B., *50-RS
Evers, Carl G., 116-PP, 138-PP, 156-PP, 170-PP, 190-PP, 210-PP, 234-PP

F

Fischer, Richard G., *161
Flowers, W. Mel, Jr., *10-RS
Frazier, Claude A., 33-L, 157-L

G

Gamble, Hugh A., II, *26
Garner, Dewey D., *129
Gibson, Nola, 99-E
Gilmore, James O., 14-PP, 30-PP, 52-PP, 78-PP, 98-PP, *132
Griffith, James E., *41

H

Hamilton, Jimmy L., *26
Hankins, Jordan H., *10-RS
Heath, Bobby J., *179
Hilbun, Lucy, 62-AP
Horton, James M., *107
Hughes, J. Preston, *223

I

Irby, Martha, *151

J

Jorensen, James A., *179

L

Lane, Larry G., 191-L
Liao, Winston C., *129
Lockey, Myron W., 15-E, 79-E, 139-E, 191-E
Lowe, Robert R., Jr., *147
Lynch, Mark, *151

M

Martin, George H., 53-E, 117-E, 171-E, 235-E
McCay, Scott, *96-RS
Mitchell, Sally Kay, 192-BR
Moore, B. O., *89

N

Nelson, Norman C., 22-L

O

Oakes, W. T., *89
Olsen, Thomas F., 192-L

P

Pankey, George A., *107
Patrick, Bernard S., *46
Philpot, Van B., Jr., *89
Pollock, William J., 142-L

R

Ray, John E., *223
Roach, Clair, 225
Roeder, Jon A., 156-L
Rowlett, Mrs. G. Samuel, Jr., 155-AP, 223-AP

S

Sanford, Robert A., *46
Secrest, Charles, *89
Sennett, Ron, *151
Sharpe, Thomas R., *5, *129
Stjernholm, Rune, *89
Stringer, Douglas R., *228-RS

T

Trubman, Aaron, *205

V

Vemureddi, Nanda Kumar, *201
Vogel, B. Frank, *23, *226

W

Walley, W. W., *93
Warren, Gene, *186-RS
Watson, David G., *179
Whiteside, Paul, *89
Williams, Charles O., *168-RS
Wilson, William B., *183

Y

Yates, Allen R., *228-RS

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Index to Advertisers

Air Force 8

Beltone Electronics Corp. 12
Burroughs Wellcome Co. 6

Canton Exchange Bank 10
Citizens Bank and Trust Co. 11
Computer Store 15
Consolidated Capital 7

Emergency Physicians 19

Guaranty Properties Bay Colony 17

Harreld Chevrolet-Oldsmobile 229

JADAM Leasing, Inc. 10

Eli Lilly and Co. 18

Mead Johnson Pharmaceutical Division 234A, 234B
Merrell-National, Inc. 10A

Pontotoc Community Hospital 19
Premier Printing Co. 14

Riverside Hospital 16
Roche Laboratories ..... second, third and fourth covers

Smith Kline and French 10B

The Upjohn Company 4

Thomas Yates and Co. 3

IN CONCLUSION

Significant findings derived from a "first time" nationwide research study on a consistent alcoholism treatment program were released by Comprehensive Care Corporation (CompCare), a national health care management company. Results include a 60% rate of total abstinence one year following discharge, with 74% indicating sobriety at follow-up. On intake consumption (one year following), CompCare's study reveals a reduced rate of absolute alcohol of more than two-thirds and a substantial reduction in psychological, vocational and other drug problems.

Members who choose to work under contract to hospitals rather than practice on a fee-for-service basis will not be penalized, American Society of Anesthesiologists agreed in a consent order. A Federal Trade Commission complaint charged that the society's "Guidelines for the Ethical Practice of Anesthesiology" advised members they should be compensanted only on a fee-for-service basis and not practice as salaried employees of hospitals. Under the order, the FTC said, the ASA must delete from its files "any record of censure" against members for past failure to comply with the policy.

A study commissioned by Eli Lilly and Company strongly supports the contention that there are quality differences among prescription drugs and among the companies that manufacture them. Using publicly available reports published by FDA, they analyzed data and examined every FDA defective product recall over a four-year period, concentrating on the most serious violations. Results showed that drug companies which do little or no research have at least seven times more recalls, 43 times more FDA-initiated court actions against them and 1½ more FDA/USP Drug Product Problem Reports.

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Proposed new federal regulations are a threat to the privacy of the medical records of millions of American working people, the AMA has charged. In a statement commenting on proposed new rule of "Access to Employee Exposure and Medical Records" of the Occupational Safety and Health Administration, AMA spokesmen said the new rule would open health records to inspection by all employees at all times and OSHA, the National Institute of Occupational Safety and Health, and to government inspection.

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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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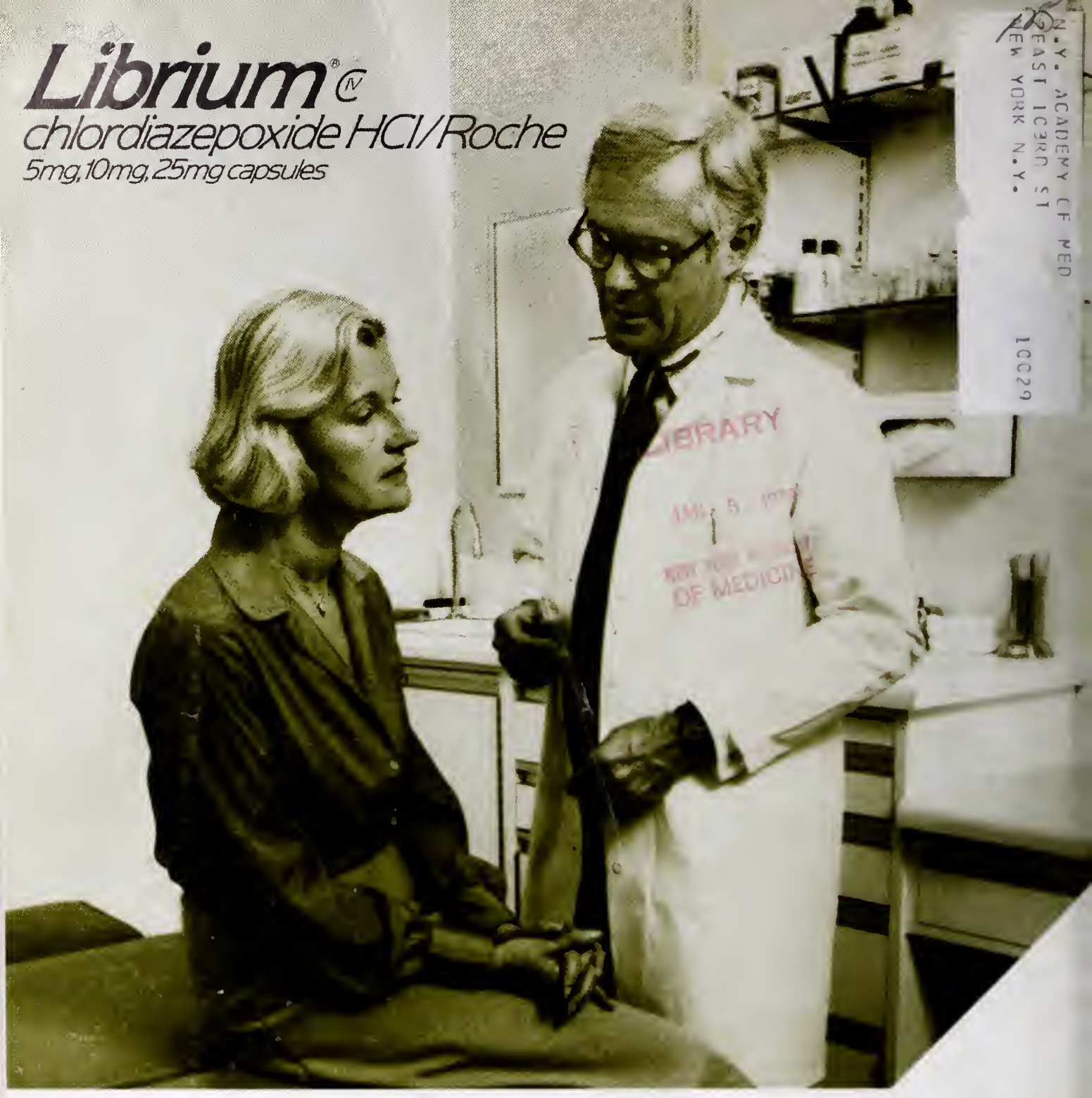
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